DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	JXE8	
Fac	ility ID: 0009	6

	IAKI I-	TO BE COMIT	DETED DI I	IIL SIAI	E SURVET AGENCI		racinty ID. 00090
1. MEDICARE/MEDICAID PROVI (L1) 245271	DER NO.	3. NAME AND AI (L3) PROVIDEN		CILITY		4. TYPE OF ACT	TION: 7 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID	NO.	(L4) 3720 23RD A	AVENUE SOU	JTH		3. Termination	4. CHOW
(L2) 797948100		(L5) MINNEAPO	DLIS, MN		(L6) 55407	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE O	FOWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	GORY	<u>02</u> (L7)		
(L9) 08/08/2007		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey A	rter Compiaint
6. DATE OF SURVEY 02 /	09/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	EICCAL VEAD EN	DING DATE: (L25)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR EN	DING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Require	ements:
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of 7. Medical	
		1. A	cceptable POC		4. 7-Day RN (Rural SN		
12. Total Facility Beds	190 (L18)				5. Life Safety Code	9. Beds/Roo	
13.Total Certified Beds	190 (L17)	X B. Not in Con Requirements	npliance with Prog and/or Applied V	-	* Code: B*	(L12)	, in
14. LTC CERTIFIED BED BREAKE	OOWN	•			15. FACILITY MEETS		
18 SNF 18/19 SNI	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
190							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Sandra Tatro, HFE NEI			02/23/2017	(L19)	Mark Meath,	Enforcement Spec	cialist 04/17/2017
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIB	SILITY		MPLIANCE WITH	H CIVIL	21. 1. Statement of Fina		
X 1. Facility is Eligible to	Participate	KIGI	IIIS ACT.		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 		
2. Facility is not Eligib							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION		(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOL</u>	UNTARY
05/29/1984					01-Merger, Closure	05-Fail	to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail	to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHE</u> F	t
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		vider Status Change
(1.27)			(L44)			00-Acti	ve
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	30	2. DETERMINATION	I OF APPROVAT	DATE			
	32						
		01/31/2017		<u> </u>			
	(L32)	01/31/2017		(L33)	DETERMINATION APP	ROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00096

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5271

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when a facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance.

As of our notice of February 17, 2017, deficiencies issued pursuant to the December 8, 2016 survey had not yet been verified. Thus, the CMS Region V Office concurred, and imposed the following remedy and authorized this Department to notify the facility of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA), effective March 8, 2017.

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP, beginning March 8, 2017.

On February 9, 2017, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the December 8, 2016 survey. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of January 17, 2017. Based on our visit, we have determined that the facility has not obtained substantial compliance with the deficiencies issued pursuant to our December 8, 2016 survey. The most serious deficiencies in the facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D). As a result of the revisit findings, the Department imposed the Category 1 remedy of State monitoring.

In addition, we recommended the following enforcement action related to the remedies in our letter of February 17, 2017:

- Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA), effective March 8, 2017, remain in effect.

Refer to the CMS 2567 along with the plan of correction and CMS 2567b. Post Certification Revisit (PCR) to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 23, 2017

Mr. Tyler Donahue, Administrator Providence Place 3720 23rd Avenue South Minneapolis, Minnesota 55407

RE: Project Number S5271028

Dear Mr. Donahue:

On February 17, 2017, as authorized by the Centers for Medicare and Medicaid Services (CMS), the Department informed you that the following enforcement remedies was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 8, 2017. (42 CFR 488.417 (b))

In addition, the Department notified you in our letter of February 17, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 8, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on December 8, 2016, and lack of verification of substantial compliance with deficiencies issued pursuant to the standard survey, as of our February 17, 2017 letter. The survey found the most seroius deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On February 9, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2017. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on February 9, 2017. The deficiencies not corrected are as follows:

F0314 -- S/S: D -- 483.25(b)(1) -- Treatment/svcs To Prevent/heal Pressure Sores

F0356 -- S/S: C -- 483.35(g)(1)-(4) -- Posted Nurse Staffing Information

F0431 -- S/S: E -- 483.45(b)(2)(3)(g)(h) -- Drug Records, Label/store Drugs & Biologicals

Providence Place February 23, 2017 Page 2

In addition, at the time of this revisit, we identified the following deficiencies:

F0282 -- S/S: D -- 483.21(b)(3)(ii) -- Services By Qualified Persons/per Care Plan F0312 -- S/S: D -- 483.24(a)(2) -- Adl Care Provided For Dependent Residents

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Department is imposing the following Category 1 remedy:

• State Monitoring effective February 28, 2017. (42 CFR 488.422)

In addition, the Department is recommending to the CMS Region V Office the following action as it related to the remedies imposed in our letter of February 15, 2017:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 8, 2017, remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of February 15, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 8, 2017.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission..

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

Providence Place February 23, 2017 Page 5

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 02/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245271	B. WING		R 02/09/2017
	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	02/03/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
{F 000}	INITIAL COMMENT	-S	{F 000]		
	of this department 2 compliance with Fe during a recertificati During this visit the determined to be no	was conducted by surveyors 2/9/17, to determine deral deficiencies issued ion survey exited on 12/8/16. following regulations were of corrected which are ectronically delivered CMS			
	signature is not req				
F 282 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility will be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 282		3/3/17
		ive Care Plans led or arranged by the facility, omprehensive care plan,			
	care. This REQUIREMEN by: Based on observat review, the facility fa individualized care p	ch resident's written plan of IT is not met as evidenced ion, interview and document		The preparation of the following place correction for this deficiency does not constitute and should not be interprated as an admission nor agreement by	ot eted
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

02/24/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		045074	B. WING			F	
		245271	B. WING			02/0	09/2017
NAME OF PRO	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDEN	CE PLACE				720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F F P (// irrantical transfer of the second	erformance deficit ADL's), potential for mpaired cognition assistance from two wo hours, dressing a mechanical full because to all destinate included encouraging ressure to skin) every and reposition are aloyer lift (a mechanassistance to move the reventions directed assistance to move the reventions directed as possible when find the day and we reakfast. R114 was aloyer sling was under the day and we reakfast. R114 was aloyer sling was under the day and we reakfast. R114 was aloyer sling was under the day and we reakfast. R114 was when dinto the television assistant (NA)-A. For anted to instead resplied, "Your room the when it's dry." the residents out of the rained medication	vised 1/25/17, indicated a in activities of daily living or pressure ulcers related to and dementia. R114 required to staff for repositioning every participated, transferring with a Hoyer lift gody lift) and assistance to cions. Staff interventions and R114 to offload (relieve every hour and encourage to at least every two hours. The el and bladder incontinence cognition and dementia. R114 are from two staff for and was transferred using a mical full body lift) and to all destinations. The electron with a meal and check	F 2	282	facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was ex solely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: 1. Resident #56 expired. Resident will have their comprehensive skin assessment and continence evaluate reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed any changes. 2. All residents residing at the facil have their comprehensive skin assessments and continence evaluate reviewed and updated to ensure accuracy. Care plans will be reviewed and updated to ensure accuracy. Care plans will be reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed to reflect a change. NAR assignment sheets were reviewed and updated as needed we changes. Comprehensive skin assessments and continence evaluation assessments and continence evaluation for completion of the comprehensive skin assessment accontinence evaluation. 3. All nursing staff will receive re education regarding process documentation for completion of the comprehensive skin assessment accontinence evaluation. 4. DNS or designee will complete the weekly audits x1 month then month audits x2 months to ensure staff compliance with residents plan of regards to their toileting and reposition of the regards t	ent of necuted visions waiving states at #114 ation ved ny vill also with ation ved ny vill be with any vill be with any vill be with any vill ations, and end random are in are in	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245271	B. WING			3
		245271	b. Wind		·	09/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
PROVIDI	ENCE PLACE			3720 23RD AVENUE SOUTH		
1110115	LITOL I LAGE			MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	5-10 degrees. R114 helps me! I want to a.m. (NA)-C was as TV room and passe have to go to the band NA-B stopped need?" R114 replie bathroom." NA-A into assist the rest of room, and then wo 9:09 a.m. R114 was the bathroom" whe back looking straig have to go to the bathroom to go to go to the bathroom to go t	k very slightly to approximately a continued to yell out "No one go to the bathroom!" At 8:58 sisting another resident to the ed by R114 as he yelled, "I athroom." A minute later NA-A to ask R114, "What do you d, "I want to go to the formed R114 they were going the residents out of the dining ald take him to his room. At smumbling, "I have to go to n he suddenly tipped his head that the ceiling and shouted, "I athroom! No one cares! I have om really bad!" Although istant director of nursing the room, neither assisted or 14. Each time a staff person m R114 informed them he oathroom. At 9:24 a.m. R114 froom when his hand started bly. At 9:27 a.m. therapeutic entered the TV room to start a 14 was still looking up at the d moving when TR-A asked and did he want to lie down or R114 reported to TR-A he R-A informed TMA-A and having pain in his groin," MA-A or ADON-A checked on I. R114 had his head/neck es were closed, and his mouth NA-C talked to R114 and e to assist the resident to get up, and then walked away. At tremors were on both sides of ms were shaking. R114 me position. At 10:56 a.m.	F 2	schedules. 5. Audit results and the be presented to the QAF monthly by the DNS or d committee will review an necessary recommendation of the property of the presented to the QAF monthly by the DNS or d committee will review an necessary recommendation.	PI committee lesignee. QAPI ld make any	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			R 09/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	up at the ceiling as area. None of the s reposition. NA-A was interview and stated he had a to the dining room a explained R114 was cares, required a H had a pressure ulce R114's Hoyer sling because, "If we try us." NA-A reported supposed to be off two hours and explained R114 had repositioning for ov NA-A verified he has tated, "Yeswe we R114 was then ass While NA-A and NA the Hoyer lift, there stool. R114's incontivery large soft stoon NA-A reported R114 with urine. In addition pressure ulcer arous slightly reddened as blanchable. His scr NA-A explained R11 and added, "This is received incontinent back to the gerichal	ge 3 ving tremors and was looking staff came and went from the taff offered to assist him to red on 2/9/17, at 11:00 a.m. assisted R114 up that day and at around 7:30 a.m. NA-A is totally dependent on staff for oyer lift for transferring, and are on his coccyx. NA-A verified was left underneath him to removed it he will fight with he was aware R114 was loaded and repositioned every ained, "We change him before in we lie him down after was brought to NA-A's been observed without er two and one half hours and not been repositioned and are going to do that now." A-B assisted R114 to bed using was a foul odor of incontinent tinent brief was removed and a lawas observed in his brief. A's brief was also slightly wet on, R114 had a healed and his buttocks that was round the area, but was otum was bright red in color. 14's scrotum was usually red the best I have seen it." R114 are care and was assisted in with the sling underneath that to the dining room for lunch.	F 28			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245271	B. WING				R 09/2017
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	1 02/	03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	During an interview licensed practical nexpected to follow levery two hour reported and possible pressure uldyesterdayWe are just open to air and doesn't reopen." R56's 12/21/15, can had a potential for prelated to incontine a history of pressur Interventions direct the resident using a cream, document a to the physician incidescription of any ware resident using a cream, document a to the physician incidescription of any ware resident using a cream, document a to the physician incidescription of any ware resident using a cream, document a to the physician incidescription of any ware resident using a cream and the physician incidescription of any ware resident and the physician incidescription and the physician inc	on 2/9/17, at 11:35 a.m. urse (LPN)-A verified staff was R114's care plan and provide ositioning. LPN-A stated eer on the left buttock "healed not putting any dressing on it to watch to make sure it re plan indicated the resident pressure ulcer development nee of bowel and bladder and	F2	282			
	8:25 a.m. to 11:08 a seated in a gerichal eating breakfast, are eating breakfast and dining room into the had head down and therapeutic recreation. TV room to hold a rethe music program with his head down R56 opened his eyes againgt side. At 10:23 a in the TV room until remained in the sar	continuously on 2/9/17, from a.m. At 8:25 a.m. R56 was ir on a Hoyer sling. R56 was and at 9:03 a.m. he finished d was wheeled out of the e TV room. At 9:08 a.m. R56 d eyes closed. At 9:27 a.m. the on staff (TR)-A came into the music program. At 9:40 a.m. started, and R56 remained and eyes closed. At 10:11 es for a few minutes, and then ain, with his body leaned to the .m. TR-B held another activity I 10:43 a.m. and R56 me position throughout the m. R56 remained in the same n the TV room.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245271	B. WING _			R / 09/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		700/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 282	stated she was res R56 that morning, a around 7:40 or 8:00 breakfast she repore explained she usual hours for incontiner him after he finished was informed it has since R56 was ass his brief changed, se asked R56 if he net which the resident could check his brief his room. NA-B exp a Hoyer lift for trans leave his Hoyer slir to take it on and off dry, he had loose se buttocks. The incor- yellowish spot of drarea on R56's button During an interview LPN-A verified R56	on 2/9/17, at 11:39 a.m. NA-B ponsible for providing care for assisted him out of bed at 0 a.m. NA-B explained after sitioned the resident. NA-B ally checked R56 every three ince, and she usually checked deating lunch. When NA-B deating lunch. When NA-B deating lunch. When NA-B deating lunch. When had she did not reply. She then eded to use the bathroom to replied "no." NA-B asked if she ef, and R56 was assisted to blained he required the use of sfers and stated, "We always and under him because it hard for the state of		32		
	per his care plan. L	PN-A said she was unaware rea, but would need to check				
		03 p.m. ADON-A stated she sition and toilet residents are plans.				
	physical therapist (occupational therap	on 2/9/17, at 3:13 p.m. PT)-A and certified pist assistant (COTA)-A stated eated in a gerichair and was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION (X3)	(X3) DATE SURVEY COMPLETED	
		245271	B. WING		R 02/09/2017	
	PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	only tipped back at angle. it would not cor repositioning. A care plan policy wreceived.	an approximate 5-10 degree constitute offloading pressure vas requested, but was not	F 282		3/3/17	
F 312 SS=D	(a)(2) A resident whactivities of daily living services to maintain personal and oral hand the personal and the personal and the personal that he wanted to in the personal personal that he wanted to in the personal that he personal pe	no is unable to carry out ing receives the necessary in good nutrition, grooming, and ygiene. NT is not met as evidenced ion, interview and document ailed to provide timely eting for 2 of 3 residents	F 312	The preparation of the following plan of correction for this deficiency does not constitute and should not be interprete as an admission nor an agreement by facility of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was execus solely because it is required by provision of state and federal law. Without waive the foregoing statement, the facility state that: 1. Resident #56 expired. Resident #1 will have their continence evaluation reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed to reflect any change. NAR assignment sheets will be reviewed and updated as needed wany changes. 2. All residents at the facility will have their continence evaluations reviewed a updated to ensure accuracy. Care plans	of d the on of ted ons ng tes 14	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7. BOILD			F	3
		245271	B. WING			02/0	09/2017
	PROVIDER OR SUPPLIER			37	TREET ADDRESS, CITY, STATE, ZIP CODE 720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	and NA-B stopped need?" R114 replie bathroom." NA-A in to assist the rest of room, and then wor 9:09 a.m. R114 was the bathroom" when back looking straighave to go to the bathroom TMA-A and the ass (ADON)-A were in the TV room needed to use the land offered toileting NA-A was interview and stated he had a to the dining room a (approximately thre NA-A explained R1 staff for cares, requiransferring, and was every two hours. Nahim before breakfa after breakfast." Whattention R114 had for over two and on had not been reposite were going to do the R114 was then ass While in his room had toilet. NA-A reporte known if he was we incontinence. While	athroom." A minute later NA-A to ask R114, "What do you d, "I want to go to the formed R114 they were going the residents out of the dining ald take him to his room. At smumbling, "I have to go to he suddenly tipped his head hat at the ceiling and shouted, "I athroom! No one cares! I have om really bad!" Although istant director of nursing the room, neither assisted or 4. Each time staff persons in R114 informed them he bathroom, however, he was or to have his brief changed. Ted on 2/9/17, at 11:00 a.m. assisted R114 up that day and at around 7:30 a.m. the and a half hours earlier). The was totally dependent on a lired a Hoyer lift for the ast to be assisted with cares A-A explained, "We change st and when we lie him down then it was brought to NA-A's been observed without cares he half hours NA-A verified he sitioned and stated, "Yeswe	F3	312	will be reviewed and updated to enaccuracy. Care plans will be review and updated as needed with any significant changes. 3. All nursing staff will receive re-education regarding process and documentation for completion of the continence evaluation. 4. DNS or designee will complete weekly audits x 1 month then month audits x2 months to ensure staff compliance with residents plan of cregards to their toileting schedules. 5. Audit results and the data collect be presented to the QAPI committed monthly by the DNS or designee. Committee will review and make an necessary recommendations.	de random nly are in sted will ee QAPI	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245271	B. WING _		02	R / 09/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	odor of incontinent was removed and a observed in his bric care and was assist A 1/13/17, significat for R114 revealed to impaired cognition, communicate and of the displayed occas behaviors, but did redependent upon state toilet, and was at the toilet, and was indestinations. Intervential the toilet, and assist destinations. Intervential the toilet, and assist destinations. Intervential the toilet, and assist destinations. Intervential the toilet, and the toilet	stool. R114's incontinent brief a very large soft stool was of. R114 received incontinence ted back to the gerichair. Int change Minimum Data Set he resident had severely however, was able to clearly comprehend communication. Sional verbal and physical not reject care. R114 was aff for transferring and using always incontinent of bowel. In activities of daily living and ence related to impaired entia. R114 required to staff for bowel care and was Hoyer lift (a mechanical full entions directed staff to toilet tossible when finished with a tery two hours for incontinence. If on 2/9/17, at 11:35 a.m. urse (LPN)-A verified R114 and changed every two hours cted to follow R114's care continuously on 2/9/17, from a.m. At 8:25 a.m. R56 was in on a Hoyer sling. R56 was and at 9:03 a.m. he finished d was wheeled out of the et TV room. At 9:08 a.m. R56 d eyes closed. At 9:27 a.m. the fon staff (TR)-A came into the	F 31	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	СОМ	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			R 09/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	1 02/	03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 312	TV room to hold a restriction the music program with his head down R56 opened his eye closed his eyes againg left side. At 10:23 a in the TV room untiversal remained in the sar activity. At 11:31 and place and position in R56's 12/1/15, indicincontinence, and vevery 2-3 hours and activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activities of daily liv was to be toileted with the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and position in the same activity. At 11:31 and place and positio	music program. At 9:40 a.m. started, and R56 remained and eyes closed. At 10:11 es for a few minutes, and then ain, with his body leaned to the a.m. TR-B held another activity I 10:43 a.m. and R56 me position throughout the m. R56 remained in the same in the TV room. Cated the resident had bowel was to be assisted with toileting d as needed. The 12/21/15, ing care plan indicated R56 with a brief change in bed. Fon 2/9/17, at 11:39 a.m. NA-B ponsible for providing care for and had assisted him out of or 8:00 a.m. NA-B explained had been repositioned, but she incontinence brief. NA-B ally checked R56 every three nce, and usually after lunch. formed it had been more than as assisted to use the ef changed, she did not reply. So if he needed to use the the resident replied "no." NA-B check his brief, and R56 was m. NA-B explained he required lift for transfers. Although the had loose stool between	F 31	2		

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ON .D BE PRIATE	(X5) COMPLETION DATE	
,	3/3/17	
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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245271	B. WING			0 2 /0	R 09/2017
	PROVIDER OR SUPPLIER			37	REET ADDRESS, CITY, STATE, ZIP CODE 720 23RD AVENUE SOUTH INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	R114 was continuo 8:25 a.m. to 11:08 a up for the day and breakfast. R114 wa Hoyer sling was un a.m. R114 was what and into the televisiassistant (NA)-A. If wanted to instead replied, "Your room there when it's dry." residents out of the Trained medication TV room passing mediar was titled bactorial bathroom." NA-A in the last the rest of room, and then word 9:09 a.m. R114 was the bathroom." NA-A in to assist the rest of room, and then word 9:09 a.m. R114 was the bathroom." whe back looking straigh have to go to the bathroom. TMA-A and the ass (ADON)-A were in the sought help for R11 entered the TV room needed to use the I remained in the TV moving uncontrollar recreation (TR)-A early and the same controllar recreation (TR)-A early an	usly observed on 2/9/17, from a.m. At 8:25 a.m. R114 was was in the dining room for is seated in a gerichair with a derneath the resident. At 8:49 seled out of the dining room on (TV) room by nursing R114 informed NA-A that he eturn to his room. NA-A floor is wet and I will take you 'NA-A continued assisting dining room to the TV room. assistant (TMA)-A was in the nedication to residents. R114's k very slightly to approximately 4 continued to yell out "No one go to the bathroom!" At 8:58 sisting another resident to the ed by R114 as he yelled, "I athroom." A minute later NA-A to ask R114, "What do you d, "I want to go to the formed R114 they were going the residents out of the dining ald take him to his room. At s mumbling, "I have to go to n he suddenly tipped his head that the ceiling and shouted, "I athroom! No one cares! I have om really bad!" Although istant director of nursing the room, neither assisted or 4. Each time a staff person m R114 informed them he oathroom. At 9:24 a.m. R114 room when his hand started bly. At 9:27 a.m. therapeutic intered the TV room to start a 14 was still looking up at the	{F 3	14}	solely because it is required by provof state and federal law. Without withe foregoing statement, the facility that. 1. Resident #56 expired. Resident will have their comprehensive skin assessment reviewed and updated ensure accuracy. Care plans will be reviewed and updated as needed to reflect any change. NAR assignment sheets will also be reviewed and updated ensure accuracy. Care plans will be reviewed with any changes. 2. All residents residing at the facil have their comprehensive skin assessments reviewed and updated ensure accuracy. Care plans will be reviewed and updated as needed to reflect any change. NAR assignments sheets will be reviewed and updated as needed with any changes. Comprehensive skin assessments reviewed quarterly, annually, and with significant changes. 3. All nursing staff will receive re-education regarding process and documentation for completion of the comprehensive skin assessment. 4. DNS or designee will complete residents plan of care in regards to repositioning schedules. 5. Audit results and the data collection presented to the QAPI committed monthly by the dns or designee. Quantities will review and make an necessary recommendations.	raiving states t # 114 to e continued ated ity will do to e continued as will be random ax2 with their example.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			R 09/2017
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	1 02/	03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	him if he was okay, stay up in his chair. was having pain. The ADON-A "[R114] is however, neither TNR114. At 10:10 a.m tipped back, his eye open. At 10:22 a.m. tried but was unable his foot tray to stay 10:34 a.m. R114's this body and his arremained in the sar R114 continued have up at the ceiling as area. None of the streposition. A 1/13/17, significant for R114 revealed the timpaired cognition, communicate and communicate and communicate and dependent upon state to liet, and was a and bladder. He had dementia and depressive for pressure ulcutime of the assessing reater and one unsutilized pressure relication. R114's care plan reperformance deficit	ge 12 d moving when TR-A asked and did he want to lie down or R114 reported to TR-A he R-A informed TMA-A and having pain in his groin," MA-A or ADON-A checked on R114 had his head/neck as were closed, and his mouth NA-C talked to R114 and a to assist the resident to get up, and then walked away. At remors were on both sides of ms were shaking. R114 me position. At 10:56 a.m. ving tremors and was looking staff came and went from the taff offered to assist him to the taff offered to assist him to the taff offered to assist him to the taff of transferring and using always incontinent of bowel diagnoses including arthritis, assion. The resident was at the nent he had one stage I or stageable pressure ulcer, and ineving devices in both the experienced frequent mild vised 1/25/17, indicated a in activities of daily living or pressure ulcers related to	{F 31			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 314}	assistance from two two hours, dressing (a mechanical full b move to all destinat included encouragin pressure to skin) eve turn and reposition NA-A was interview	and dementia. R114 required o staff for repositioning every it, transferring with a Hoyer lift ody lift) and assistance to ions. Staff interventions ng R114 to offload (relieve very hour and encourage to at least every two hours.	{F 31	4}		
	to the dining room a explained R114 was cares, required a H had a pressure ulce R114's Hoyer sling because, "If we try us." NA-A reported supposed to be off two hours and explain breakfast and when breakfast." When it attention R114 had repositioning for ow NA-A verified he had	assisted R114 up that day and at around 7:30 a.m. NA-A is totally dependent on staff for over lift for transferring, and is on his coccyx. NA-A verified was left underneath him to removed it he will fight with he was aware R114 was loaded and repositioned every ained, "We change him before in we lie him down after was brought to NA-A's been observed without er two and one half hours d not been repositioned and are going to do that now."				
	While NA-A and NA the Hoyer lift, there stool. R114's incont very large soft stool NA-A reported R114 with urine. In addition pressure ulcer arous slightly reddened arblanchable. His scruNA-A explained R11	sted to his room at 11:08 a.m. a-B assisted R114 to bed using was a foul odor of incontinent inent brief was removed and a was observed in his brief. 4's brief was also slightly wet on, R114 had a healed and his buttocks that was round the area, but was otum was bright red in color. 14's scrotum was usually red the best I have seen it." R114				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			B) DATE SURVEY COMPLETED	
		245271	B. WING				R 09/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE	
{F 314}	received incontinent back to the gerichal him and was broug R114's wound sumbealed pressure uld documented on 1/3 = 100%; 2) left butto and 2/8/17, as intacted and 2/8/17, as intacted practical nexpected to follow fevery two hour reports to pen to air and doesn't reopen." R56 was observed 8:25 a.m. to 11:08 a seated in a gerichal eating breakfast, are eating breakfast, are eating breakfast and dining room into the had head down and therapeutic recreation. TV room to hold a return the music program with his head down R56 opened his eyes againgt side. At 10:23 and in the TV room until remained in the sar activity. At 11:31 a.r. place and position in the sar activity. At 11:31 a.r. place and position in the sar activity. At 11:31 a.r. place and position in the sar activity.	ce care and was assisted in with the sling underneath that to the dining room for lunch. mary revealed two recently sers. 1) left ischial tuberosity 1/17 and 2/8/17, as intact skin ock documented on 1/25, 1/31 st skin=100%. on 2/9/17, at 11:35 a.m. urse (LPN)-A verified staff was R114's care plan and provide sitioning. LPN-A stated ser on the left buttock "healed not putting any dressing on it to watch to make sure it continuously on 2/9/17, from a.m. At 8:25 a.m. R56 was in on a Hoyer sling. R56 was and at 9:03 a.m. he finished d was wheeled out of the enusic program. At 9:40 a.m. started, and R56 remained and eyes closed. At 10:11 ser for a few minutes, and then ain, with his body leaned to the m. TR-B held another activity 10:43 a.m. and R56 me position throughout the m. R56 remained in the same	{F 3-	14}				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			R	
	PROVIDER OR SUPPLIER	240271		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	•	/09/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{F 314}	related to incontiner a history of pressur. Interventions directed the resident every to lift, utilize barrier crechanges in skin to to stage and description. During an interview stated she was resp. R56 that morning, a around 7:40 or 8:00 breakfast she reposexplained she usual hours for incontiner him after he finished was informed it had since R56 was assishis brief changed, so asked R56 if he need which the resident recould check his brief is room. NA-B explained she usual hours for incontiner him after he finished was informed it had since R56 was assishis brief changed, so asked R56 if he need which the resident recould check his brief is room. NA-B explained and she had loose stouttocks. The inconvellowish spot of drawarea on R56's button During an interview LPN-A verified R56 toileting and been reper his care plan. L	pressure ulcer development ince of bowel and bladder and e ulcer on the hip. ed staff to check and change we hours using a mechanical eam, document and report any he physician including the on of any wounds. on 2/9/17, at 11:39 a.m. NA-B consible for providing care for assisted him out of bed at a.m. NA-B explained after sitioned the resident. NA-B lly checked R56 every three ince, and she usually checked deating lunch. When NA-B been more than three hours sted to use the toilet or had the did not reply. She then edded to use the bathroom to replied "no." NA-B asked if she ef, and R56 was assisted to blained he required the use of fers and stated, "We always g under him because it hard." Although R56's brief was nool between the folds of his tinence brief also had a gainage from an open circular	{F 3-	14}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE	
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	PROVIDER OR SUPPLIER			37	TREET ADDRESS, CITY, STATE, ZIP CODE 720 23RD AVENUE SOUTH INNEAPOLIS, MN 55407	UZ/	55/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	expected staff repo according to their can During an interview physical therapist (Foccupational therapif a resident was se only tipped back at	o3 p.m. ADON-A stated she sition and toilet residents are plans. on 2/9/17, at 3:13 p.m.	{F 3·	14}			
{F 356} SS=C	The facility's 9/10, F Prevention Program directed staff to mo pressure ulcer prev development and p monitor the inciden- ulcers within the fac to policies and proc application and con standards of practic	Providence Place Pressure n Policy and Procedure nitor the effectiveness of the ention program to reduce the rogression of pressure ulcers, ce and prevalence of pressure cility, and monitor adherences redures for consistency in formance with the current ce.	{F 3	56}			3/3/17
	483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis:						
	(i) Facility name.						
	(ii) The current date) .					
	by the following cate	er and the actual hours worked egories of licensed and staff directly responsible for nift:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245271	B. WING				ີ 09/2017
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(X4) ID PREFIX TAG					BE	(X5) COMPLETION DATE	
{F 356}	Continued From pa	ge 17	{F 35	56}			
	(A) Registered nurs	es.					
		cal nurses or licensed as defined under State law)					
	(C) Certified nurse	aides.					
	(iv) Resident censu	S.					
	(2) Posting requirer	nents.					
	specified in paragra	post the nurse staffing data uph (g)(1) of this section on a eginning of each shift.					
	(ii) Data must be po	ested as follows:					
	(A) Clear and reada	able format.					
	(B) In a prominent presidents and visito	place readily accessible to rs.					
	The facility must, up make nurse staffing	posted nurse staffing data. con oral or written request, data available to the public not to exceed the community					
	facility must mainta staffing data for a m required by State la This REQUIREMEN by:	ention requirements. The in the posted daily nurse ninimum of 18 months, or as w, whichever is greater. NT is not met as evidenced ion, interview and document			The preparation of the following pl	an of	
	review, the facility father the beginning of the	ailed to post nursing hours at a shift as required. This had at all 163 residents residing in			correction for this deficiency does reconstitute and should not be interpase an admission nor an agreement	not reted	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /		ATE SURVEY DMPLETED
		245271	B. WING		0	R 2/09/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		2/00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 356}	public display on 2/3 the previous day 2/3 residents. On 2/9/1 NHP for public disp census of 165. In an interview with at 3:36 p.m. on 2/9/ staffing person who 8:00-8:30 a.m. wen verify staff who wer and the daily censu beginning of the da beginning of the eve the facility policy wa a.m. each morning. meeting was held a staff a better unders discharges and beg weekends the week responsible for posi 4:57 p.m. the DON decided to post the	Hours Posting (NHP) for 9/17, at 7:30 a.m. was dated 8/17, with a census of 163 7, at 1:44 p.m. the posted lay was dated 2/9/17, with a the director of nursing (DON) 17, the DON explained the arrived at work between to each nursing station to e not present, overtime hours, s. The DON stated the y shift was 6:30 a.m. and the ening shift was 2:30 p.m. and as to post the NHP at 10:00 Additionally, a morning to 9:00 a.m. at which gave the standing of admissions, I holds for the day. On the tend supervisor was ting the NHP at 10:00 a.m. At explained the facility had NHP once daily at 10:00 a.m.	F 35	facility of the truth of the factonclusions set forth in the stafficiencies. The plan of comprepared for this deficiency solely because it is required of state and federal law. Withe foregoing statement, the that: 1. Daily nursing hours were 2/9/2017 prior to survey exit 2. The policy and procedure posting of nursing hours was ensure regulatory compliant 3. Education was complete staffing coordinator and built supervisors regarding the performance for the daily nursing postings. 4. ED or designee will completely audits x 2 months to ensure compliance with daily nursing posting. 5. Audit results and the data be presented to the QAPI completely audits will review and mecessary recommendation.	statement of prection was execute by provision thout waiving a facility state posted on a	d s s s
{F 431} SS=E	indicated the purporthat is accessible for reviewThe inform basis and updated v483.45(b)(2)(3)(g)(h LABEL/STORE DR	policy for posting musing hours see was "To post nursing hours or resident and/or family ation will be posted on a daily with changes for each shift." DRUG RECORDS, UGS & BIOLOGICALS Divide routine and emergency	{F 43	31}		3/3/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	COM	(X3) DATE SURVEY COMPLETED		
		245271	B. WING _			R 09/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
{F 431}	them under an agre §483.70(g) of this punlicensed personn law permits, but on supervision of a lice (a) Procedures. At pharmaceutical ser that assure the acc dispensing, and adbiologicals) to meet (b) Service Consult employ or obtain th pharmacist who (2) Establishes a sy disposition of all codetail to enable and (3) Determines that that an account of a maintained and per (g) Labeling of Drug and biological abeled in accordant professional princip appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance with facility must stolocked compartment.	als to its residents, or obtain between the described in part. The facility may permit held to administer drugs if State by under the general ensed nurse. Facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and at the needs of each resident. Action. The facility must be services of a licensed vices of a licensed vices are in order and all controlled drugs in sufficient accurate reconciliation; and all controlled drugs is incidically reconciled. Ags and Biologicals. The facility must be not be used in the facility must be not with currently accepted bles, and include the ory and cautionary expiration date when	{F 43	1}				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING		R 02/09	/2017
	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	02,00	. = 0 - 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETION DATE
{F 431}	permanently affixed controlled drugs list Comprehensive Druction Control Act of 1976 abuse, except when package drug distriquantity stored is more readily detected. This REQUIREMENT by: Based on observative review, the facility fand/or dispose medication dates for R5, R32, R228, R96 medication carts medication storage. Findings include: On 2/9/17, at 9:30 a stated, "We are to dissulins upon openity worked on the transity was assigned to worked on the label. It is resident's last name mark on the label. It is resident's last name mark on the label. It is resident's forder date 2 directed staff to adriance Aerosol Solution	t provide separately locked, a compartments for storage of ted in Schedule II of the tag Abuse Prevention and and other drugs subject to a the facility uses single unit bution systems in which the tinimal and a missing dose can of the tag and the	{F 431}	The preparation of the following placorrection for this deficiency does reconstitute and should not be interpras an admission nor agreement by facility of the truth of the facts alleg conclusions set forth in the statemed eficiencies. The plan of correction prepared for this deficiency was exsolely because it is required by proof state and federal law. Without withe foregoing statement, the facility that: 1. pharmacy was consulted and idmedication carts were audited. Expand/or undated medications were disposed of and replacement medicordered as needed. 2. All medication carts were audited any undated or expired medications disposed of and replaced as needed. 3. A process was developed for perinspections of the medication carts includes ensuring medications are when opened as required and expired medications are removed. 4. ED or designee will complete ra	reted the ed on ent of n ecuted visions vaiving states entified circd cations d and s were ed. vriodic that dated red	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		JILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED			
		245271	B. WING				ີ 09/2017
	PROVIDER OR SUPPLIER			37	TREET ADDRESS, CITY, STATE, ZIP CODE 720 23RD AVENUE SOUTH INNEAPOLIS, MN 55407	<u> 02/0</u>	J9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
{F 431}	puffs." RN-D reported on 2 facility's guidelines posted on the bulle station. RN-B explained on was working on cal 3N medication cart verified the label iss R39's opened eye on to dated when operapproximately 1/2 r label indicated "1/0 taught to label med expiration dates up were not labeled whassume the opened therefore, R39's eye considered expired RN-B stated she plant Maleate as it had enew one. R39's phy "Timolol Maleate Schoth eyes as needed ordered 1/4/17. R3's indicated a diagnos R39's face sheet no R39 of 1/4/17. R7's bottle of Xalatalabeled when opened when opened whad to then assume the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be a sum of the plant RN-B stated she could be	ge 21 2/9/17, at 9:46 a.m. the for medication expiration were tin board at the nursing 2/9/17. at 10:39 a.m. that she I and had not worked on the since the previous week, but sues on the medication cart. drops Timolol Maleate were ened. The eye drops had emaining, and the pharmacy 4/17." RN-B said she was ications with shortened on opening; if medications nen opened, the nurse was to d date was the pharmacy date, e drops should have been 30 days later, on 2/4/17. anned to discard the Timolol expired and then would order a visician orders included plution 0.5% Instill 1 drop in the dor, two times daily," 2/9's physician orders also is of unspecified glaucoma. Other and admission date for the was opened, but was not each an admission date for the was opened on 1/26/17. The pharmacy RN-R stated on the pharmacy RN-R stated on the pharmacy RN-R stated.	{F 43	31}	weekly audits x1 month then month audits x2 months to ensure staff compliance with medication cart inspections. 5. Audit results and the data collect be presented to the QAPI committed monthly by the ED or designee. Question committee will review and make an necessary recommendations.	cted will ee API	

AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COMPLETED		
		245271	B. WING _			R 09/2017	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE	
{F 431}	3/9/17, as Xalatan vafter opening. R7's indicated "Latanopr Instill 1 drop in left order dated 6/10/16 On 2/9/17, at 11:37 assistant (TMA)-A cwas to check the exeye drops and to dawhen opened. R5's bottle of Latan undated with just unverified the finding, administering eye oviable for 30 days. Seen labeled when how long they shou stated physician's cadminister eye drare good for that or orders indicated "La Instill 1 drop in both primary open-angle 5/13/14. On 2/9/17, at 12:21 administered eye drate eye drops and R32's discus Advair puffs remained. TM indicated the Advair	e the bottle as expired on was only good for 42 days current physician orders ost Solution [Xalatan] 0.005% eye at bedtime for glaucoma" is. a.m. trained medication on 3 south (3S) unit said staff (piration dates when opening ate eye drops and inhalers oprost was opened, and was noder half remaining. TMA-A as well as responsibility for rops, and knew they were since R5's eye drops had not opened, TMA-A was unsure ld have been kept. TMA-A orders on the medication rod directed the number of days rops," So I know the eye drops der." R5's current physician atanoprost Solution 0.005% eyes at bedtime related to glaucoma" order dated p.m. TMA-B stated she rops and inhalers and was to inhalers upon opening. Twas opened, undated and 35 A-B verified the Advair label thad been refilled on 1/16/17, lasts for 30 days after	{F 43 ⁻¹				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		245271	B. WING	i			R 09/2017
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE				STREET ADDRESS, CITY, STATE, ZIP 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	CODE	UZ/	03/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD IE APPROPF	BE	(X5) COMPLETION DATE
{F 431}	undated with 118 puindicated on the lab dated the inhaler 2/And Expiration Guid Symbicort expired tuse. R228's current "Budesonide-Forma [Symbicort] 160-4.5 two times a day" for R97's bottle of Timedated 12/30/16. The stated, "Someone paway." TMA-B stated drops to R97 that mottle of eye drops TMA-B then located been opened but worth TMA-B stated, "I widay I talked to you." bottle of eye drops pharmacy, and said TMA-B then said shottle 1/28/17 versuphysician orders in (Timolol Maleate) In times a day for dry R97's 2/17, MAR in receiving Timolol Se 8:00 a.m. and 8:00 On 2/9/17, at 2:21 padminister eye drops staff, "Technically sinhalers upon open drops were only effectives."	bicort Ver was opened, uffs remaining. The refill date of was 2/6/17, and TMA-B 6/17. A Medication Storage delines sheet indicated hree months after the first ophysician orders indicated, oterol Fumarate Aerolsol of mcg/Act 2 puff inhale orally of COPD, order dated 12/30/16. Tolol Mal Sol was opened, or bottle was empty and TMA-B orobably forgot to throw it of she had administered eye norning, and there was another labeled with R97's name. If the second bottle that had as not dated when opened. If date this bottle today, the of After asking TMA-B when the had been delivered from the late label indicated 1/28/17. The would instead date the second solution 0.5% of the second bottle storage of the word of the label indicated 1/28/17. The would instead date the second solution 0.5% of the second bottle of the label indicated 1/28/17. The word of the		31}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	COV	(X3) DATE SURVEY COMPLETED		
		245271	B. WING			R /09/2017		
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE				STREET ADDRESS, CITY, STATE, ZIP COD 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	02/09/2017 DE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SECTION SEC	HOULD BE	(X5) COMPLETION DATE		
{F 431}	(LPN)-B reviewed the surveyor. LPN-B stainhalers and eye dra dated when opened and different times expiration dates on other medications of they could use the dates. R4's bottle of eye doundated and slightly date on the label of using the pharmacy drops would have ended the pharmacy." R4'dated 12/8/16, directly dated 12/8/17, dated 12/8/17, dated 12/8/17, dated 12/8/17, dated 12/8/17, dated 12/8/17, directly dated 12/8/17, directly displayed the second the survey drops, however bottle was labeled to R4's name. LPN-B label that had the word that had the word the survey drops, directly displayed to R24's bottle of eye undated, approximated the survey dated, approximated the survey dated, approximated the survey dated, approximated the survey dated, approximated the survey dated approximated the surve	c.m. licensed practical nurse he 2S medication cart with the lated shortened time frame ops were supposed to be la, because they had shorter to dispose of than the the medication. LPN-B stated did not have to be dated, and manufacturer's expiration rops Xalatan was opened, y over half full with a pharmacy 12/22/16. LPN-B reported of date which meant R4's eye expired 2/2/17. LPN-B stated, roy the bottle and reorder from scurrent physician orders ceted "Xalatan Solution 0.005% 1 drop in right eye at bedtime tivitis." R4's 2/17, MAR even receiving Xalatan Solution each evening at 8:00 p.m. (six days past the expiration experience of the with the R204's name versus stated it was just the reorder rrong resident's name, and not urrent physician orders active ted staff to administer Systane .3% eye drops for dry eyes. drops Xalatan was opened, ately one fifth full, and had a 2/6/16. LPN-B stated the eye	{F 43					

AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245271	B. WING _		02	R / 09/2017		
	PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CO 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
{F 431}	am going to destroy second bottle of Xa undated, and more refill 1/7/17 exp [ex physician orders in 0.005% Instill 1 dro related to unspecifi 8/26/16. R24's 2/17 been receiving Xalaboth eyes at bedtim glaucoma daily 2/1 expiration date). R59's bottle of eye undated, and was orefill date "exp 2/21 LPN-B. R59's 2/17, receiving Latanopro both eyes at bedtim date 4/14/16). On 2/9/17, at 2:46 pthe TMAs administrinhalers, and eye dadministered insulinknow who opened said, "probably a ni an undated, opened pharmacy date [on was sent."	expired 1/17/17, and stated, "I y and reorder." LPN-B verified alatan for R24 was opened, than half full and "pharmacy pires] 2/18/17." R24's current dicated, "Xalatan Solution p in both eyes at bedtime ed glaucoma" order dated Y, MAR indicated R24 had at an Solution 0.005% 1 drop in the related to unspecified to 2/8/17, (past the 1/17/17 drops Xalatan was opened, over half full with a pharmacy 1/17" which was verified by MAR indicated R59 had been out 0.005% eye drops nightly in the for glaucoma in 2/17 (order one. TMA-C stated typically ered more of the medications, rops, and the nurses in TMA-C stated she did not the Xalatan eye drops, but ght or evening nurseIf I saw did eye drops I would go by the the label] and know when it sing (DON) stated on 2/9/17, at and inhalers on the eand Expiration Guidelines		1)				
	were dated upon of shorter time frame date. The DON sta	bening because they had a to use than the expiration ted she would talk to the cist (CP) about medications						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED		
		245271	B. WING			R / 09/2017		
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE				STREET ADDRESS, CITY, STATE, ZIP COI 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		09/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE		
{F 431}	DON reported she informed her Xalata 42 days after opening harm from using the drops after that date receiving optimal distated she had eduregarding dating me expiration dates followed competed audits of storage system. The facility provided And Expiration Guid medication Symbiology when opened, and use; Advair Discus opened, and expire Xalatan eye drops wopened, and expire Timolol Maleate eye opened, and expire The same guideline medications found	ge 26 e frames. At 3:26 p.m. the talked to the CP. The CP an eye drops were viable for ng. Although there was no e product itself, using the e resulted in potential for not sease control. The DON cated all nurses and TMAs edications with shortened lowing the last survey, and had the facility's medication d 8/15, Medication Storage delines that indicated out inhalers were to be dated expired three months after 1st was to be dated when d 30 days after foil opened; were to be dated when d 42 days after 1st use; and e drops were to be dated when d one month after opened. Es also indicated, "Specified undated when opened will be been opened as of the date of	{F 4:	31}				

POST-CERTIFICATION REVISIT REPORT

1 001 OEITH IOAHON NEVION NEI OITH									
	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	ISIT				
245271 _{Y1}	B. Wing		Y2	2/9/2017	Y3				
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE							
PROVIDENCE PLACE 3720 23RD AVENUE SOUTH									
		MINNEAPOLIS, MN 55407							
This report is completed by a q	ualified State surveyor for the Medicare, N	ledicaid and/or Clinical Laboratory Improvem	nent	Amendments					

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix Reg. #	483.10(c)(2)(i-ii	Correction Completed	ID Prefix F0412 483.55 Reg. #	5(b)(1)(2)(5)	Correction Completed	ID Prefix	F0441 483.80(a)(1)(2)(4)	(e)(f)	Correction Completed
LSC	(3),483.21(b)(2)	02/09/2017	LSC		2/09/2017	LSC			02/09/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. # LSC		Completed	Reg. #	C	Completed	Reg. #			Completed
		Compostion			\				Cowertion
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #			Correction Completed
LSC		' ' 	LSC		'	LSC			'
ID Prefix		Correction	ID Prefix	C	Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #	C	Completed	Reg. #			Completed
LSC			LSC	_		LSC			
ID Prefix		Correction	ID Prefix	c	Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #	C	Completed	Reg. #			Completed
LSC			LSC			LSC			
STATE A		REVIEWED BY (INITIALS) GL/mm	DATE 02/23/2017	SIGNATURE OF SU	IRVEYOR 086			DATE 02/0	9/2017
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/8/2016				R ANY UNCORRECTE CTED DEFICIENCIES			IE E4 OU IE (O	YE:	S 🗆 NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 15, 2017

Mr. Tyler Donahue, Administrator Providence Place 3720 23rd Avenue South Minneapolis, Minnesota 55407

RE: Project Number S5271028

Dear Mr. Donahue:

On December 27, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 8, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2017. However, compliance with the health deficiencies issued pursuant to the December 8, 2016 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 8, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 8, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 8, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Providence Place is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective

Providence Place February 15, 2017 Page 2

March 8, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services

Departmental Appeals Board, MS 6132

Director, Civil Remedies Division

330 Independence Avenue, S.W.

Cohen Building – Room G-644

Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

Providence Place February 15, 2017 Page 3

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		F	2
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVIDI	ENCE PLACE		DAVENUE S OLIS, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency found that the deficiency for the Minnesota Department of the Minnesota Department of the Minnesota Department of the Minnesota Pepartment of the Corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected. You may request a that may result from	nether a violation has been compliance with all a rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was the hearing on any assessments a non-compliance with these				
	orders provided that the Department with	t a written request is made to hin 15 days of receipt of a https://or non-compliance.				
	2/9/17. During this of all deficiencies were 2567). The uncorre effect and will be re	rs: visit was completed on consite visit it was determined e not corrected (see CMS cted orders will remain in viewed at the next onsite visit, d for possible penalty				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/24/17 **Electronically Signed**

If continuation sheet 1 of 20

(X6) DATE

JXE812

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMPI	
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PROVIDI	ENCE PLACE		D AVENUE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			3/3/17
	by: Based on observatireview, the facility faindividualized care	olan for repositioning and esidents (R56, R114) whose		acknowledged.		
	R114's care plan re performance deficit (ADL's), potential for impaired cognition a assistance from two two hours, dressing (a mechanical full b move to all destinational included encouraging pressure to skin) eviturn and reposition R114 also had bower related to impaired required assistance incontinence care a Hoyer lift (a mechanassistance to move Interventions directed	and was transferred using a nical full body lift) and to all destinations. ed staff to toilet R114 as soon nished with a meal and check				

Minneso	<u>ta Department of He</u>	ealth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
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		00096	B. WING			9/2017
					<u> </u>	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PROVIDE	ENCE PLACE		D AVENUE S			
		MINNEAP	OLIS, MN 5	5407		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG			IAG	DEFICIENCY)		
0.505	0	0	0.505			
2 565	Continued From pa	ige 2	2 565			
	R114 was continuo	usly observed on 2/9/17, from				
	8:25 a.m. to 11:08 a	a.m. At 8:25 a.m. R114 was				
	up for the day and	was in the dining room for				
		s seated in a gerichair with a				
		derneath the resident. At 8:49				1
		eeled out of the dining room				
		on (TV) room by nursing				1
		R114 informed NA-A that he				1
		eturn to his room. NA-A				1
		floor is wet and I will take you				1
		' NA-A continued assisting				1
		dining room to the TV room.				1
		assistant (TMA)-A was in the nedication to residents. R114's				1
		k very slightly to approximately				1
		4 continued to yell out "No one				1
	ū	go to the bathroom!" At 8:58				
		ssisting another resident to the				
		ed by R114 as he yelled, "I				
		athroom." A minute later NA-A				
		to ask R114, "What do you				
		d, "I want to go to the				1
		formed R114 they were going				1
		the residents out of the dining				1
	room, and then wor	uld take him to his room. At				1
		s mumbling, "I have to go to				
	the bathroom" whe	n he suddenly tipped his head				
	back looking straigl	nt at the ceiling and shouted, "I				
	have to go to the ba	athroom! No one cares! I have				1
		om really bad!" Although				1
		istant director of nursing				1
		the room, neither assisted or				1
		4. Each time a staff person				1
		m R114 informed them he				1
		oathroom. At 9:24 a.m. R114				
		room when his hand started				
		bly. At 9:27 a.m. therapeutic				
		ntered the TV room to start a				
	music program. R1	14 was still looking up at the				Ì

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	ceiling with his handhim if he was okay, stay up in his chair. was having pain. The ADON-A "[R114] is however, neither TI R114. At 10:10 a.m tipped back, his eye open. At 10:22 a.m tried but was unable his foot tray to stay 10:34 a.m. R114's this body and his arremained in the sar R114 continued have up at the ceiling as area. None of the sreposition. NA-A was interview and stated he had a to the dining room a explained R114 was cares, required a Hhad a pressure ulcon R114's Hoyer sling because, "If we try us." NA-A reported supposed to be off two hours and explained R114 had repositioning for ow NA-A verified he has stated, "Yeswe we R114 was then ass While NA-A and	d moving when TR-A asked and did he want to lie down or R114 reported to TR-A he R-A informed TMA-A and having pain in his groin," MA-A or ADON-A checked on . R114 had his head/neck es were closed, and his mouth . NA-C talked to R114 and e to assist the resident to get up, and then walked away. At tremors were on both sides of ms were shaking. R114 me position. At 10:56 a.m. ving tremors and was looking staff came and went from the taff offered to assist him to red on 2/9/17, at 11:00 a.m. assisted R114 up that day and at around 7:30 a.m. NA-A is totally dependent on staff for over lift for transferring, and er on his coccyx. NA-A verified was left underneath him to removed it he will fight with he was aware R114 was loaded and repositioned every ained, "We change him before a we lie him down after was brought to NA-A's been observed without er two and one half hours and not been repositioned and ere going to do that now."	2 565			

Minnesota Department of Health

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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PROVIDI	ENCE PLACE		D AVENUE S OLIS, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	stool. R114's incont very large soft stool NA-A reported R114 with urine. In addition pressure ulcer arous slightly reddened as blanchable. His scrond-A explained R1 and added, "This is received incontinent back to the gericha him and was broug During an interview licensed practical nexpected to follow fevery two hour reportant processor of the processor of the stool of the processor of the procesor of the processor of the processor of the processor of the proc	cinent brief was removed and a l was observed in his brief. 4's brief was also slightly wet on, R114 had a healed and his buttocks that was round the area, but was otum was bright red in color. 14's scrotum was usually red the best I have seen it." R114 ce care and was assisted ir with the sling underneath hit to the dining room for lunch. on 2/9/17, at 11:35 a.m. urse (LPN)-A verified staff was R114's care plan and provide ositioning. LPN-A stated cer on the left buttock "healed not putting any dressing on it to watch to make sure it				
	had a potential for prelated to incontine a history of pressur Interventions direct the resident using a cream, document a to the physician inc description of any wand was to be toilet needed. R56 was observed 8:25 a.m. to 11:08 a seated in a gerichal eating breakfast, ar eating breakfast and seated in a content of the present of the physician includes the physici	re plan indicated the resident pressure ulcer development ince of bowel and bladder and e ulcer on the hip. He are to check and change a mechanical lift, utilize barrier and report any changes in skin luding the stage and wounds. R56 was incontinent and every 2-3 hours or as continuously on 2/9/17, from a.m. At 8:25 a.m. R56 was in on a Hoyer sling. R56 was and at 9:03 a.m. he finished d was wheeled out of the e TV room. At 9:08 a.m. R56				

Minnesota Department of Health

STATE FORM JXE812 If continuation sheet 5 of 20

Minnesota Department of Health

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I LAN	OF CONTLCTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVII	LLILD
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PROVID	ENCE PLACE		OLIS, MN 5			
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				BEI IGIENGT)		
2 565	Continued From pa	ge 5	2 565			
	had head down and	d eyes closed. At 9:27 a.m. the				
		on staff (TR)-A came into the				
		nusic program. At 9:40 a.m.				
		started, and R56 remained				
	with his head down	and eyes closed. At 10:11				
		es for a few minutes, and then				
		ain, with his body leaned to the				
		.m. TR-B held another activity I 10:43 a.m. and R56				
		ne position throughout the				
		m. R56 remained in the same				
	place and position i					
		on 2/9/17, at 11:39 a.m. NA-B				
		consible for providing care for				
		assisted him out of bed at				
		a.m. NA-B explained after sitioned the resident. NA-B				
		Ily checked R56 every three				
		nce, and she usually checked				
		d eating lunch. When NA-B				
		been more than three hours				
		sted to use the toilet or had				
		she did not reply. She then				
		eded to use the bathroom to				
		replied "no." NA-B asked if she				
		ef, and R56 was assisted to plained he required the use of				
		sfers and stated, "We always				
		g under him because it hard				
		." Although R56's brief was				
		tool between the folds of his				
	buttocks. The incor	itinence brief also had a				
		ainage from an open circular				
	area on R56's butto	ock.				
	During on internit	on 9/0/17, at 11:25 a				
		on 2/9/17, at 11:35 a.m. should have been offered				
		epositioned every 2-3 hours				
		PN-A said she was unaware				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED	
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	PROVIDER OR SUPPLIER	3720 23RI	DRESS, CITY, S D AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	on it. Later that day at 2:0 expected staff repo according to their case. During an interview physical therapist (Foccupational therapif a resident was seenly tipped back at angle, it would not cor repositioning.	rea, but would need to check 03 p.m. ADON-A stated she sition and toilet residents are plans. on 2/9/17, at 3:13 p.m.	2 565			
{2 905}	Subp. 4. Positionin positioned in good to of residents unable must be changed a including periods of been put to bed for has documented th hours during this tin the physician has of this MN Requirements. Based on observation review, the facility for minimize the risk development of presidents unable to minimize the risk development of presidents.	g. Residents must be pody alignment. The position to change their own position to change their own position to least every two hours, time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or ordered a different interval. The period is unnecessary or ordered and different interval. The period is unnecessary or ordered and document ailed to provide repositioning for reoccurrence or further source ulcers for 2 of 3 wiewed for pressure ulcers.	{2 905}	acknowledged		3/3/17

Minnesota Department of Health

A. BUILDING: A. BUILDING: COMPLETED	STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407 (X5) COMPLET (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
PROVIDENCE PLACE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
PROVIDENCE PLACE MINNEAPOLIS, MN 55407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PROVIDER OR SUF
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	PROVIDENCE PLACE
SEL GLIGH,	PREFIX (EACH DEFI
Findings include: R114 was continuously observed on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R114 was up for the day and was in the dining room for breakfast. R114 was seated in a gerichair with a Hoyer sling was underneath the resident. At 8:49 a.m. R114 was wheeled out of the dining room and into the television (TV) room by nursing assistant (NA)-A. R114 informed NA-A that he wanted to instead return to his room. NA-A replied, "Your room floor is wet and 1 will take you there when it's dry." NA-A continued assisting residents out of the dining room to the TV room. Trained medication assistant (TMA)-A was in the TV room passing medication to residents. R114's chair was titled back very slightly to approximately 5-10 degrees. R114 continued to yell out "No one helps me! I want to go to the bathroom!" At 8:58 a.m. (NA)-C was assisting another resident to the TV room and passed by R114 as he yelled, "I have to go to the bathroom." A minute later NA-A and NA-B stopped to ask R114, "What do you need?" R114 replied, "I want to go to the bathroom." A hinformed R114 they were going to assist the rest of the residents out of the dining room, and then would take him to his room. At 9:09 a.m. R114 was mumbling, "I have to go to the bathroom" NA-A informed R114 they were going to assist the rest of the residents out of the dining room, and then would take him to his room. At 9:09 a.m. R114 was mumbling, "I have to go to the bathroom!" NA-A in the assistant director of nursing (ADON)-A were in the room, neither assisted or sought help for R114. Each time a staff person entered the TV room R114 informed them he needed to use the bathroom the hand started moving uncontrollably, At 9:27 a.m. therapeutic	Findings inclusions and the page to go to and NA-B sto need?" R114 bathroom." Not oassist the room, and the page to go to to go to the bathroom back looking the page to the page to go to and the page to go to to go to the bathroom back looking the page to go to to go to go to the page to go

Minnesota Department of Health

Minnesota Department of Health

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{2 905}	ceiling with his handhim if he was okay, stay up in his chair. was having pain. TI ADON-A "[R114] is however, neither TI R114. At 10:10 a.m tipped back, his eye open. At 10:22 a.m tried but was unable his foot tray to stay 10:34 a.m. R114's this body and his arremained in the sar R114 continued havup at the ceiling as area. None of the sreposition. A 1/13/17, signification for R114 revealed to timpaired cognition, communicate and dependent upon state toilet, and was a and bladder. He had dementia and deprorisk for pressure ulcation of the assessing greater and one unutilized pressure rechair and bed. He expain. R114's care plan reperformance deficit	ge 8 14 was still looking up at the d moving when TR-A asked and did he want to lie down or R114 reported to TR-A he R-A informed TMA-A and having pain in his groin," MA-A or ADON-A checked on R114 had his head/neck es were closed, and his mouth NA-C talked to R114 and eto assist the resident to get up, and then walked away. At tremors were on both sides of ms were shaking. R114 me position. At 10:56 a.m. ving tremors and was looking staff came and went from the taff offered to assist him to Int change Minimum Data Set he resident had severely however, was able to clearly comprehend communication. Sional verbal and physical not reject care. R114 was aff for transferring and using always incontinent of bowel diagnoses including arthritis, ession. The resident was at cer development, and at the nent he had one stage I or stageable pressure ulcer, and lieving devices in both the experienced frequent mild experienced frequent mild or pressure ulcers related to	{2 905}			

Minnesota Department of Health

STATE FORM JXE812 If continuation sheet 9 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE :	
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PROVIDENCE PLACE		D AVENUE S POLIS, MN 5			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
assistance from two hours, dressi (a mechanical furmove to all destinincluded encourar pressure to skin) turn and reposition. NA-A was interviated and stated he had to the dining roor explained R114 was required a had a pressure und R114's Hoyer slir because, "If we the us." NA-A reported supposed to be a two hours and expression of the stated, "Yeswe repositioning for NA-A verified he stated, "Yeswe R114 was then a While NA-A and the Hoyer lift, the stool. R114's incovery large soft stones are under a slightly reddened blanchable. His side NA-A explained Fig. 1.	n and dementia. R114 required wo staff for repositioning everying, transferring with a Hoyer lift body lift) and assistance to ations. Staff interventions ging R114 to offload (relieve every hour and encourage to nat least every two hours. Ewed on 2/9/17, at 11:00 a.m. dassisted R114 up that day and nat around 7:30 a.m. NA-A was totally dependent on staff for Hoyer lift for transferring, and cer on his coccyx. NA-A verified g was left underneath him y to removed it he will fight with dhe was aware R114 was ff loaded and repositioned every plained, "We change him before en we lie him down after it was brought to NA-A's ad been observed without over two and one half hours had not been repositioned and were going to do that now." Sesisted to his room at 11:08 a.m. NA-B assisted R114 to bed using re was a foul odor of incontinent on tinent brief was removed and a follow was observed in his brief. 14's brief was also slightly wet was a foul odor of incontinent on tinent brief was removed and a follow was observed in his brief. 14's brief was also slightly wet was a foul odor of incontinent on the area, but was around the area, but was around the area, but was around the area, but was crotum was bright red in color. It was scrotum was usually red is the best I have seen it." R114				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	3
		00096	B. WING			9/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PROVID	ENCE PLACE		D AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{2 905}	back to the gerichal him and was brough R114's wound summed the lead pressure uld documented on 1/3 = 100%; 2) left butto and 2/8/17, as intaction of the lead of	ir with the sling underneath int to the dining room for lunch. mary revealed two recently iters. 1) left ischial tuberosity 1/17 and 2/8/17, as intact skin ick documented on 1/25, 1/31 it skin=100%. on 2/9/17, at 11:35 a.m. urse (LPN)-A verified staff was R114's care plan and provide iositioning. LPN-A stated iter on the left buttock "healed into putting any dressing on it it to watch to make sure it. continuously on 2/9/17, from a.m. At 8:25 a.m. R56 was in on a Hoyer sling. R56 was in on staff (TR)-A came into the interpretation of t	{2 905}			
	had a potential for p	pressure ulcer development nce of bowel and bladder and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING.		F	2
	00096	B. WING			9/2017
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVIDENCE PLACE		D AVENUE S			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Interventions dire the resident every lift, utilize barrier of changes in skin to stage and descript. During an intervie stated she was read that morning around 7:40 or 8: breakfast she repexplained she use hours for incontinhim after he finish was informed it has ince R56 was as his brief changed asked R56 if he nowhich the resident could check his bear his room. NA-Bear a Hoyer lift for trace leave his Hoyer stotake it on and of dry, he had loose buttocks. The ince yellowish spot of area on R56's but the per his care plantage. Barrier leave his care plantage. Later that day at 2 the change of the resident per his care plantage. Later that day at 2 the resident per his care plantage.	ure ulcer on the hip. cted staff to check and change two hours using a mechanical cream, document and report any the physician including the tion of any wounds. w on 2/9/17, at 11:39 a.m. NA-B sponsible for providing care for assisted him out of bed at 00 a.m. NA-B explained after ositioned the resident. NA-B stally checked R56 every three ence, and she usually checked ded eating lunch. When NA-B ad been more than three hours sisted to use the toilet or had she did not reply. She then eeded to use the bathroom to the replied "no." NA-B asked if she rief, and R56 was assisted to explained he required the use of the staff	{2 905}			

Minnesota Department of Health

STATE FORM JXE812 If continuation sheet 12 of 20

Minnesota Department of Health			_			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORNECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMP	LETED
		00096	B. WING		02/0	R 1 9/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
			D AVENUE S			
PROVIDE	ENCE PLACE		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 905}	Continued From pa	ge 12	{2 905}			
	physical therapist (Foccupational therapif a resident was seen only tipped back at angle. it would not correpositioning. The facility's 9/10, Forevention Program directed staff to mo pressure ulcer previously development and pomonitor the incident ulcers within the fact to policies and process.	poist assistant (COTA)-A stated that a gerichair and was an approximate 5-10 degree constitute offloading pressure. Providence Place Pressure in Policy and Procedure into the effectiveness of the rention program to reduce the rogression of pressure ulcers, ce and prevalence of pressure cility, and monitor adherences reduce for consistency in informance with the current				
2 920	Subp. 6. Activities comprehensive reshome must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920			3/3/17
	This MN Requirements by: F312	ent is not met as evidenced		acknowleged		
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			3/3/17
	Drugs used in the n	nursing home must be labeled part 6800.6300.				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:		R	
		00096	B. WING			1 9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		D AVENUE S			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
21620	Continued From pa	ge 13	21620			
	This MN Requirements: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to properly label, store dications with shortened 11 residents (R99, R39, R7, 7, R4, R204, R24, R59) in 4 of on 4 of 4 units reviewed for a.m. registered nurse (RN)-A date eye drops, inhalers and ng." RN-A stated she usually sitional care unit, but that day		acknowledged		
	R99's hfa aerosol in crossed out in black resident's last name mark on the label. For scratched off" the R99's (order date 2 directed staff to adrosol Solution1 hours as needed for Chronic Obstructive puffs." RN-D reported on 2 facility's guidelines posted on the bullet station. RN-B explained on was working on call	ark on the 2 north (N) unit. Thaler pharmacy label was a marker, with only the evisible though the black RN-A stated someone had other pertinent information. The province of the province of the pulling of the pertinent information. The pulling or all yevery 4 and pulling of the previous week, but the previous wee				

Minnesota Department of Health

winnesc	ita Department of He	ailli				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	3
		00096	B. WING			9/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
10 101	THO VIBERT OF TOOL TELEFT		D AVENUE S	•		
PROVIDI	ENCE PLACE		OLIS, MN 5			
(V4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	.D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				22.10.2.10.1		
21620	Continued From pa	ge 14	21620			
	verified the label iss	sues on the medication cart.				
	R39's opened eve	drops Timolol Maleate were				
		ened. The eye drops had				
		emaining, and the pharmacy				
		4/17." RN-B said she was				
	· ·	ications with shortened				
		on opening; if medications nen opened, the nurse was to				
		d date was the pharmacy date,				
		e drops should have been				
		30 days later, on 2/4/17.				
		anned to discard the Timolol				
		xpired and then would order a				
		sician orders included				
		olution 0.5% Instill 1 drop in ed for, two times daily,"				
		9's physician orders also				
		is of unspecified glaucoma.				
		oted an admission date for				
	R39 of 1/4/17.					
	D71- 414 V- -4					
		an was opened, but was not ed. The bottle was less than				
		armacy label date was 1/26/17.				
		ould not tell when the bottle				
		vithout an opened date, but				
		e it was opened on 1/26/17,				
		the pharmacy. RN-B stated				
		the bottle as expired on				
		was only good for 42 days current physician orders				
		ost Solution [Xalatan] 0.005%				
		eye at bedtime for glaucoma"				
	order dated 6/10/16					
	0:: 0/0/47 = 1.44 07	and the language of the state of				
		a.m. trained medication				
		on 3 south (3S) unit said staff xpiration dates when opening				

Minnesota Department of Health

eye drops and to date eye drops and inhalers

STATE FORM JXE812 If continuation sheet 15 of 20

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	
		00096	B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PROVID	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From page 15 when opened.		21620			
	undated with just un verified the finding, administering eye of viable for 30 days. Seen labeled when how long they shou stated physician's of administration reco to administer eye do are good for that or orders indicated "La Instill 1 drop in both	oprost was opened, and was nder half remaining. TMA-A as well as responsibility for lrops, and knew they were Since R5's eye drops had not opened, TMA-A was unsure ld have been kept. TMA-A orders on the medication rd directed the number of days rops," So I know the eye drops der." R5's current physician atanoprost Solution 0.005% a eyes at bedtime related to glaucoma" order dated				
	On 2/9/17, at 12:21 p.m. TMA-B stated she administered eye drops and inhalers and was to date eye drops and inhalers upon opening.					
	puffs remained. TM indicated the Advair	r was opened, undated and 35 IA-B verified the Advair label r had been refilled on 1/16/17, lasts for 30 days after says 30 days."				
	undated with 118 puindicated on the lab dated the inhaler 2/And Expiration Guid Symbicort expired tuse. R228's current "Budesonide-Forma [Symbicort] 160-4.5 two times a day" for	bicort Ver was opened, uffs remaining. The refill date pel was 2/6/17, and TMA-B 6/17. A Medication Storage delines sheet indicated hree months after the first t physician orders indicated, pterol Fumarate Aerolsol of mcg/Act 2 puff inhale orally of COPD, order dated 12/30/16.				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
			A. BOILDING.		F	}
		00096	B. WING			9/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PROVIDE	ENCE PLACE		DAVENUE S			
(V4) ID	SHIMMADV STA	ATEMENT OF DEFICIENCIES)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 16	21620			
	stated, "Someone paway." TMA-B stated drops to R97 that mottle of eye drops TMA-B then located been opened but w TMA-B stated, "I widay I talked to you.' bottle of eye drops pharmacy, and said TMA-B then said shottle 1/28/17 versuphysician orders ind (Timolol Maleate) In times a day for dry R97's 2/17, MAR in receiving Timolol Se 8:00 a.m. and 8:00					
	administer eye drop staff, "Technically s inhalers upon open drops were only effo days, when they we a potency level.	o.m. TMA-C stated she could os and inhalers and stated the hould date eye drops and ing." TMA-C stated some eye ective a recommended 30-60 ould not be considered to have				
	(LPN)-B reviewed the surveyor. LPN-B state inhalers and eye draward dated when opened and different times expiration dates on other medications of	c.m. licensed practical nurse he 2S medication cart with the ated shortened time frame tops were supposed to be d, because they had shorter to dispose of than the the medication. LPN-B stated did not have to be dated, and manufacturer's expiration				

Minnesota Department of Health STATE FORM

R4's bottle of eye drops Xalatan was opened,

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Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
			7.11 2012211101		F	}
		00096	B. WING	·····	02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
PROVIDENCE PLACE			O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	undated and slightly date on the label of using the pharmacy drops would have e "I am going to destrough the pharmacy." R4's dated 12/8/16, direct [Latanoprost] Instill for chronic conjunct indicated R4 had be 0.005% eye drops from 2/1 to 2/8/17, (date). While peeling the reeye drops, however bottle was labeled v R4's name. LPN-B label that had the with the bottle. R204's cas of 1/23/17, direct Ultra Solution 0.4-0. R24's bottle of eye undated, approximate pharmacy date of 1 drops would have eam going to destroy second bottle of Xa undated, and more refill 1/7/17 exp [exp physician orders inco.005% Instill 1 drop related to unspecific 8/26/16. R24's 2/17 been receiving Xalaboth eyes at bedtimes."	ge 17 y over half full with a pharmacy 12/22/16. LPN-B reported date which meant R4's eye expired 2/2/17. LPN-B stated, oy the bottle and reorder from scurrent physician orders eted "Xalatan Solution 0.005% 1 drop in right eye at bedtime tivitis." R4's 2/17, MAR een receiving Xalatan Solution each evening at 8:00 p.m. (six days past the expiration existed it was just the reorder rong resident's name versus stated it was just the reorder rong resident's name, and not current physician orders active ted staff to administer Systane and system of the system o	21620			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		R	
		00096	B. WING			1 9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		D AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	R59's bottle of eye undated, and was orefill date "exp 2/21 LPN-B. R59's 2/17, receiving Latanopro both eyes at bedtim date 4/14/16). On 2/9/17, at 2:46 pthe TMAs administering inhalers, and eye diadministered insuling know who opened the said, "probably a nighal undated, opened pharmacy date [on was sent." The director of nurse 3:18 p.m. eye drops Medication Storage were dated upon opened to said. The DON state consulting pharmacy with shortened times both reported sheet informed her Xalata 42 days after opening harm from using the drops after that data receiving optimal distated she had eduregarding dating me expiration dates foll competed audits of storage system.	drops Xalatan was opened, over half full with a pharmacy /17" which was verified by MAR indicated R59 had been ost 0.005% eye drops nightly in the for glaucoma in 2/17 (order out. TMA-C stated typically ered more of the medications, rops, and the nurses of the Xalatan eye drops, but ght or evening nurse				
	The facility provided	d 8/15, Medication Storage delines that indicated				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
		00096			F 02/0	? 9/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	02/0	9/2017
			DAVENUE S			
PROVIDI	ENCE PLACE	MINNEAP	OLIS, MN 5	5407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
	when opened, and use; Advair Discus opened, and expire Xalatan eye drops vopened, and expire Timolol Maleate eye opened, and expire The same guideline medications found in the same state.	ort inhalers were to be dated expired three months after 1st was to be dated when d 30 days after foil opened; were to be dated when d 42 days after 1st use; and e drops were to be dated when d one month after opened. Es also indicated, "Specified undated when opened will be been opened as of the date of				

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			STAT	E FORM: RE\	/ISIT	REPORT					
	ER / SUPPLIER / CLIA / ICATION NUMBER Y1	MULTIPLE CON A. Building B. Wing	STRUCTIC	DN				Y2	DATE (OF REVISIT	3
	NAME OF FACILITY PROVIDENCE PLACE STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407										
corrective identification	This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).										
ITE	М	DATE	ITEM	ļ		DATE	ITEM			DATE	
Y4		Y5	Y4			Y5	Y4			Y5	
ID Prefix Reg. #	20570 MN Rule 4658.0405 Subp. 4	Correction Completed	ID Prefix Reg. #	21335 MN Rule 4658.072 Subp. 3 A&B	25	Correction Completed	ID Prefix Reg. #	21375 MN Rule 4658.08 Subp. 1	300	Correction	
LSC		02/09/2017	LSC			02/09/2017	LSC			02/09/2017	
-											_

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

DATE

LSC

LSC

LSC

Correction

Completed

02/09/2017

Correction

Completed

Correction

Completed

Correction

Completed

REVIEWED BY (INITIALS) GL/mm

REVIEWED BY

(INITIALS)

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

LSC

LSC

LSC

Correction

Completed

X

FOLLOWUP TO SURVEY COMPLETED ON

ID Prefix 21610

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

REVIEWED BY

REVIEWED BY

CMS RO

12/8/2016

STATE AGENCY

LSC

LSC

LSC

LSC

MN Rule 4658.1340

Subp. 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JXE8
Facility ID: 00096

MEDICARE/MEDICAID PROVID						
(L1) 245271 2.STATE VENDOR OR MEDICAID 1 (L2) 797948100		3. NAME AND AI (L3) PROVIDEN (L4) 3720 23RD A (L5) MINNEAPO	ICE PLACE AVENUE SOU		(L6) 55407	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 08/08/2007	OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 12/06 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	8/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	190 (L18) 190 (L17)	Compliance1. A X B. Not in Con	equirements e Based On:	gram	And/Or Approved Waivers Of 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: B*	7. Medical Director
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF	OWN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Mary Bruess, HFE NEII		0	01/11/2017	(L19)	Mark Meath	, Enforcement Specialist 01/30/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF ELIGIBII _X 1. Facility is Eligible to 1 2. Facility is not Eligible			IPLIANCE WITI			
	-		HTS ACT:	H CIVIL		uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE	e		HTS ACT: 4. LTC AGREEN		Ownership/Contr	ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE OF PARTICIPATION 05/29/1984	(L21)	MENT 24		MENT	2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 0 01-Merger, Closure	ol Interest Disclosure Stmt (HCFA-1513) e: (L30) INVOLUNTARY 05-Fail to Meet Health/Safety
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00096

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5271

On December 8, 2016, a standard survey was completed at the facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation regulations. This survey found the most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E). In addition, at the time of the December 8, 2016 standard survey an investigation of complaint numbers H5271186 and H5271188 were conducted and found to be unsubstantiated. Refer to the CMS 2567 along with the facility's plan of correction for both health and life safety code. Post Certification Revisit (PCR) to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 27, 2016

Mr. Tyler D. Donahue, Administrator Providence Place 3720 23rd Avenue South Minneapolis, Minnesota 55407

RE: Project Number S5271028, H5271186 and H5271188

Dear Mr. Donahue:

On December 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 8, 2016 standard survey an investigation of complaint numbers H5271186 and H5271188 were conducted and found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gayle Lantto, Unit Supervisor Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 17, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 8, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

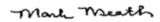
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER PROPRIATE PROVIDER PLAN OF CORRECTION (EACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPANIANT OR COMPANIA			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	COMPLETED		
STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			245271	B. WING			12/08/2016		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PRÉFIX TAG					3	3720 23RD AVENUE SOUTH			
The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. At the time of the Recertification survey, investigations were conducted into complaints H5271186 and H5271188. The complaints were not substantiated. F 280 483.10 (c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE	
not substantiated. F 280 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request	F 000	The facility's plan of as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with	FC	0000				
(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	SS=D	not substantiated. 483.10(c)(2)(i-ii,iv,v) PARTICIPATE PLA 483.10 (c)(2) The right to p and implementation plan of care, includi (i) The right to parti including the right to be included in the p request meetings a revisions to the per (ii) The right to part expected goals and amount, frequency, other factors related plan of care.	participate in the development of his or her person-centered ing but not limited to: cipate in the planning process, or identify individuals or roles to planning process, the right to not the right to request son-centered plan of care. icipate in establishing the di outcomes of care, the type, and duration of care, and any di to the effectiveness of the		280			1/17/17 (X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

01/11/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2017 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED		
		245271	B. WING		12/0) 08/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	12/0	,0,2313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 280	Continued From page 1 (iv) The right to receive the services and/or items included in the plan of care.		F 28	0				
		the care plan, including the gnificant changes to the plan						
	(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must (i) Facilitate the inclusion of the resident and/or resident representative.							
	(ii) Include an assesstrengths and need	ssment of the resident's s.						
		resident's personal and in developing goals of care.						
	483.21 (b) Comprehensive	Care Plans						
	(2) A comprehensiv	e care plan must be-						
	(i) Developed withir the comprehensive	n 7 days after completion of assessment.						
	(ii) Prepared by an includes but is not I	interdisciplinary team, that imited to						
	(A) The attending p	hysician.						
	(B) A registered nur resident.	se with responsibility for the						
	1		1					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271			(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		B. WING		C 12/08/2016			
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE				STREET ADDRESS, CITY, STATE, ZIP CO 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	-		
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F 280	resident. (D) A member of formula (E) To the extent puthe resident and the An explanation multimedical record if the and their resident root practicable for the resident's care plans. (F) Other appropriate disciplines as determined as requested by (iii) Reviewed and the team after each as comprehensive and assessments. This REQUIREMED by: Based on observative, the facility from the services to minimize development of presidents (R149) residents (R149) resid	od and nutrition services staff. cacticable, the participation of e resident's representative(s). It is included in a resident's representative is determined the development of the nutre staff or professionals in mined by the resident's needs the resident. The vised by the interdisciplinary resessment, including both the did quarterly review Nor is not met as evidenced the risk for further resident and e the risk for further resure ulcers for 1 of 2 reviewed with pressure ulcers. The plan for R149 (revised on the resident had the potential development related to so, incontinence, and sheering. Ited turning and repositioning at arrs, or more frequently as	F2	The preparation of the follow correction for these deficient constitute and should not be as an admission nor an agrefacility of the truth of the fact conclusions set forth in the seficiencies. The plan of comprepared for this deficiency was solely because it is required of state and federal law. With the foregoing statement, the that with respect to; 1. Resident #149 was exam podiatry on 12/12/16 with dia non-pressure related wounds to footwear irritation and poor	cies does not interpreted rement be the salleged on statement of rrection was executed be provisions thout waiving facility states ined by agnosed s secondary		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDENCE PLACE STREET ADDRESS, CITY, STATE, ZIP CODE 3720 3RD AVENUE SOUTH MINNEAPOLIS, MN 55407	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
PROVIDENCE PLACE X3 10							С	
PROVIDENCE PLACE X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG COMMENTIFY NOR INFORMATION	245271		B. WING			12/0	08/2016	
MINNEAPOLIS, MN 55407	NAME OF F	PROVIDER OR SUPPLIER						
F 280 Continued From page 3 R149 was observed continuously on 12/7/16, from 12:10 p.m. until 2:48 p.m. without repositioning. At 12:10 he was in a wheelchair in the dining room eating lunch. At 1:04 registered nurse (RN)-I assisted R149 to his room and performed a dressing change as ordered to both feet. At 1:20 an exercise activity was offered to the resident but was declined. At 1:22 RN-I left the room, and no repositioning in the wheelchair was offered or performed during the time RN-I was in R149's room. R149 remained seated in his wheelchair with his eyes closed from 1:28 until 1:53 when the resident's vital signs were taken; the resident was not repositioning was not offered. At 2:38 RN-I stated there were only two NAs on the floor from 2:30 to 3:00. At 2:44 NA-A stated R149 was not in her "regular group" but she was "covering" for NA-B. NA-A stated staff was to offload R149 every two hours, but she was unable to state when R149 had last been repositioned explaining,	PROVIDENCE PLACE							
R149 was observed continuously on 12/7/16, from 12:10 p.m. until 2:48 p.m. without repositioning. At 12:10 he was in a wheelchair in the dining room eating lunch. At 1:04 registered nurse (RN)-I assisted R149 to his room and performed a dressing change as ordered to both feet. At 1:20 an exercise activity was offered to the resident but was declined. At 1:22 RN-I left the room, and no repositioning in the wheelchair was offered or performed during the time RN-I was in R149's room. R149 remained seated in his wheelchair with his eyes closed from 1:28 until 1:53 when the resident's vital signs were taken; the resident was not repositioned. Nursing assistant (NA-C) asked R149 at 2:03 if he needed anything. When asked if he needed his incontinence brief changed or to use the toilet the resident denied being incontinent and replied, "Not now." Repositioning was not offered. At 2:38 RN-I stated there were only two NAs on the floor from 2:30 to 3:00. At 2:44 NA-A stated R149 was not in her "regular group" but she was "covering" for NA-B. NA-A stated staff was to offload R149 every two hours, but she was unable to state when R149 had last been repositioned explaining,	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
"I would not know," and stated she did not get a report when she arrived on the unit. At 2:48 R149 remained in his wheelchair without repositioning. During a staff interview on 12/5/16, at 5:10 p.m. the registered nurse (RN-D) stated R149 had developed a pressure ulcer on each of his bilateral (both sides) great toes. She explained the pressure areas were due to edema in his lower extremities and feet which caused his shoes to become tight resulting in pressure, and were unstageable (could not be visualized). A round education on 12/14/16. 5. The director of nursing and/or designee will audit three residents each week for one month and then two residents per week for two months to assure the plan of care for the individual resident is appropriate for promoting healing and preventing further breakdown. 6. The data collected will be presented to the QAPI committee be the Director of Nursing. The data will be reviewed/discussed at the monthly quality	F 280	R149 was observed from 12:10 p.m. unrepositioning. At 12 the dining room eat nurse (RN)-I assist performed a dressifeet. At 1:20 an exithe resident but was the resident but was offered or performed as in R149's room his wheelchair with 1:53 when the resident was not assistant (NA-C) as needed anything. Wincontinence brief or resident denied bei "Not now." Repositi RN-I stated there we from 2:30 to 3:00. Anot in her "regular of for NA-B. NA-A state every two hours, but when R149 had las "I would not know," report when she arremained in his who buring a staff interval the registered nurse developed a pressubilateral (both sides the pressure areas lower extremities as shoes to become times the state of the state o	d continuously on 12/7/16, till 2:48 p.m. without till 2:49 p.m. without and any change as ordered to both ercise activity was offered to seelined. At 1:22 RN-I left epositioning in the wheelchair formed during the time RN-I n. R149 remained seated in his eyes closed from 1:28 until dent's vital signs were taken; of repositioned. Nursing sked R149 at 2:03 if he when asked if he needed his changed or to use the toilet the ng incontinent and replied, oning was not offered. At 2:38 were only two NAs on the floor at 2:44 NA-A stated R149 was group" but she was "covering" ted staff was to offload R149 at she was unable to state at been repositioned explaining, and stated she did not get a rived on the unit. At 2:48 R149 eelchair without repositioning. View on 12/5/16, at 5:10 p.m. to the explained were due to edema in his of great toes. She explained were due to edema in his not feet which caused his ght resulting in pressure, and	F 2	280	In addition to podiatry exam, a comprehensive skin and reposition evaluation has been completed. C wounds were entered into the wour rounds program for weekly monitor a braden assessment completed. care plan has been revised to inclumeasures for care, monitoring and treatment of the residents vascular wounds. The NAR assignment she have been revised to reflect the chaz. All residents with current wound had their care plans reviewed and as indicated to include all measure prevention, treatment, care and monitoring of their current wound was revisions as indicated to reflect any changes. 3. All nursing staff will be re-educate regarding completing comprehensing risk assessment and accuracy of the Braden to determine risk. Education be completed be Ed. Meaux of wour ound. 4. All nurse leadership received wor round education on 12/14/16. 5. The director of nursing and/or designee will audit three residents week for one month and then two residents per week for two months assure the plan of care for the indiving and preventing further breadents appropriate for promotion healing and preventing further breadents appropriate be the Directon Nursing. The data will be	urrent ind ing and R149 de eets anges. s have revised s for rith ted ve skin ne on will und each to ridual g kdown. inted to r of	

the cause of both the left and the right great toe

make the decision/recommendation

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING		COMPLETED	
	245271		B. WING		C 12/08/2016		
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			;	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		<u> </u>	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	.D BE	(X5) COMPLETION DATE	
F 280	R149's most recent assessment dated was at risk for skin of diabetes, lymphe and bladder, and in further indicated R1 breakdown at that the R149's Compreher Evaluation dated 9/skin factors for the skin often moist, very potential problem for R149's quarterly Mi 12/1/16, required estaff for bed mobilitindicated the reside ulcers on his feet. In devices in the chair turning and reposition of the resident permitted for R149 were required buring a staff interval RN-D stated nursin report off to oncom	related and facility acquired. It Care Assessment Area 6/9/16, identified the resident breakdown due to diagnosis edema, incontinence of bowel amobility. The assessment 149 did not have skin time. It is skin and Positioning 1/2/16, identified contributing 1/2/16, identified the resident 1/2/16, identified the session identified contribution 1/2/16, identified contributing 1/2/1	F 280	regarding any necessary follow up studies.)		
	During a staff interv RN-D stated nursin report off to oncom shift. She further st policy or standardiz	view on 12/7/16, at 2:58 p.m. g assistants (NAs) were to ing NAs at the end of their					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245271	B. WING _			C 08/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		55/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314 SS=D	documented versus repositioned. On 12/8/16, at 10:5 stated she expected residents as directed the individual needs. The facility's 9/10, Forevention Program directed staff to mo pressure ulcer previous development and program and program directed staff to mo pressure ulcer previous and program directed staff to mo pressure ulcer previous and program directed staff to mo pressure ulcers within the factor policies and program directed staff to mo pressure ulcers and program directed staff to mo pressure ulcers undersided to policies and program directed staff to mo pressure ulcers. (b) Skin Integrity - (1) Pressure ulcers comprehensive assignating must ensure (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that the comprehensional standar professional standar standards and standards are standards are standards and standards are standards are standards and standards are standar	eflected the time it was a the time the resident was at the time the resident was at the time the resident was at the time the resident was a staff to provide care to do in their care plans to meet a of the resident. Providence Place Pressure and Procedure ention the effectiveness of the resident of pressure ulcers, and prevalence of pressure consistency in formance with the current see. TMENT/SVCS TO RESSURE SORES Based on the resident, the	F 28			1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(3) DATE SURVEY COMPLETED C	
		245271	B. WING			; 8/2016
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	from developing. This REQUIREMEI by: Based on observatoreview, the facility for services to minimiz development of presidents (R149) residents (R149) resident a dressifeet. At 1:20 an exthe resident but was the room, and no rewas offered or perfewas in R149's room his wheelchair with 1:53 when the resident was not assistant (NA-C) as needed anything. Vincontinence brief or resident denied bei "Not now." Repositing RN-I stated there we from 2:30 to 3:00. Anot in her "regular of the resident stated there we from 2:30 to 3:00. Anot in her "regular of the R149 had lassing the resident stated there we from R149 had lassing the resident stated there we from R149 had lassing the resident stated there we from R149 had lassing the resident stated there we from R149 had lassing the R149 had lassing the resident stated there we from R149 had lassing the R149 had lassing the resident stated there we from R149 had lassing the R149 had lass	ge 6 NT is not met as evidenced tion, interview and document ailed to provide care and e the risk for further assure ulcers for 1 of 2 viewed with pressure ulcers. It continuously on 12/7/16, til 2:48 p.m. without 10 he was in a wheelchair in ing lunch. At 1:04 registered and R149 to his room and any change as ordered to both ercise activity was offered to see declined. At 1:22 RN-I left expositioning in the wheelchair formed during the time RN-I and R149 remained seated in his eyes closed from 1:28 until dent's vital signs were taken; for repositioned. Nursing sked R149 at 2:03 if he when asked if he needed his changed or to use the toilet the ang incontinent and replied, oning was not offered. At 2:38 were only two NAs on the floor at 2:44 NA-A stated R149 was group" but she was "covering" ted staff was to offload R149 at she was unable to state to been repositioned explaining, and stated she did not get a	F 314	,	ndary ulation. ing urrent and ring and R149 de sets anges. Is have revised s for with d as ted ensive of the on will and red each	
	report when she are	rived on the unit. At 2:48 R149		assure the plan of care for the indiversident is appropriate for promoting	/idual	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	СОМ	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			C 08/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	•	
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F 314	the registered nurs developed a press bilateral (both sides the pressure areas lower extremities a shoes to become t were unstageable. Wound Summary State cause of both tulcers as pressure. The current care p 2/12/14), indicated for pressure ulcer of immobility, diabete Interventions include least every two howneeded or requested. R149's most recent assessment dated was at risk for skin of diabetes, lympholand bladder, and infurther indicated R breakdown at that the R149's Compreher Evaluation dated 9 skin factors for the skin often moist, very potential problem for R149's quarterly M12/1/16, required estaff for bed mobility.	view on 12/5/16, at 5:10 p.m. le (RN-D) stated R149 had lure ulcer on each of his les) great toes. She explained lie were due to edema in his light resulting in pressure, and light resident the resident to seed turning and repositioning at light resulting in pressure, and light resulting in pressure, and light resulting and repositioning at light resulting in pressure, and light resulting in p	F3	healing and preventing 5. The data collected w the QAPI committee by nursing. The data will be reviewed/discussed at t meeting. At this time the make the decision/reco regarding any necessar studies.	rill be presented to the director of be he monthly Quality he committee will mmendation	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 314	ulcers on his feet. Indevices in the chair turning and reposition. The Active [physicial directed staff to offloor standing) from the if the resident perm. The current Treatm directs staff to offloor if resident permitted for R149 were requived. During a staff interved RN-D stated nursing report off to oncomishift. She further stapolicy or standardized process. She further Point of Care, but redocumented versus repositioned. On 12/8/16, at 10:5 stated she expected residents as directed the individual needs. The facility's 9/10, Forevention Program directed staff to moderate prevention to the incident ulcers within the factor policies and process.	de had pressure relieving and bed, but did not have a oning program. In Orders as of 11/25/16, bad (relieve pressure by lifting the wheelchair every two hours itted (start date of 7/29/13). The ent Administration Record and from wheelchair every hour did Weekly wound flow sheets the ested but not obtained. It was on 12/7/16, at 2:58 p.m. of assistants (NAs) were to ng NAs at the end of their ated there was no written the dreport sheet used for this estated the NAs reported in the effected the time it was the time the resident was at the time the resident of the resident. Providence Place Pressure of the ention program to reduce the regression of pressure ulcers, and prevalence of pressure edures for consistency in formance with the current	F3	814			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			C 12/08/2016	
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F 356 F 356 SS=C	Continued From pa 483.35(g)(1)-(4) PC INFORMATION	ge 9 OSTED NURSE STAFFING	F 3 F 3				1/17/17
		nformation ents. The facility must post ation on a daily basis:					
	(i) Facility name.						
	(ii) The current date) .					
	by the following cate	er and the actual hours worked egories of licensed and staff directly responsible for hift:					
	(A) Registered nurs	es.					
		cal nurses or licensed as defined under State law)					
	(C) Certified nurse	aides.					
	(iv) Resident censu	S.					
	(2) Posting requirer	nents.					
	specified in paragra	post the nurse staffing data uph (g)(1) of this section on a eginning of each shift.					
	(ii) Data must be po	ested as follows:					
	(A) Clear and reada	able format.					
	(B) In a prominent presidents and visito	place readily accessible to rs.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		COMI	COMPLETED	
	245271	B. WING			C 08/2016	
			3720 23RD AVENUE SOUTH	12/	30/2010	
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE	
(3) Public access to The facility must, up make nurse staffing for review at a cost standard. (4) Facility data rete facility must mainta staffing data for a nor required by State later This REQUIREMENT by: Based on observation interview, the facility in the manner required affect all residents at Findings include: Posted nursing hour 12/5/16, at 11:45 a. 2/6/16, at 11:30 a.n. were dated 12/5/16 On 12/7/16, at 9:45 (DON) explained the policy, they had unthours were posted process" of posting reflected staffing for In an interview with 12/7/16, at approximate the staff had been previous day's staff said she had been	posted nurse staffing data. con oral or written request, g data available to the public not to exceed the community ention requirements. The in the posted daily nurse ninimum of 18 months, or as tw, whichever is greater. NT is not met as evidenced tion, document review and y failed to post nursing hours ired. This has the potential to and visitors. a.m. the director of nursing at according to the facility's il 10:00 a.m. to ensure the for the day. They were "in the the hours, and later the hours r 12/7/16. the staffing coordinator on mately 11:00 a.m. she stated costing the hours to reflect the ing. The staffing coordinator told effective that day	F 350	 With respect to posting facility the actual hours worked were con and posted on 5/24/2016 prior to sexit. The staffing coordinator receiveducation regarding the requirement posting the Nursing hours in a time manner. The guideline for posting nursing has been reviewed and revised for implementation. The executive director and/or will audit the posting for accuracy timeliness each week for three measure compliance. The data collected will be presented the QAPI committee by the executive director and/or designee. The data reviewed/discussed at the monthly assurance meeting. At this time to committee will make the 	ed ent for ely ng hours r designee and onths to ented to tive a will be y quality he QAPI		
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa (3) Public access to The facility must, up make nurse staffing for review at a cost standard. (4) Facility data rete facility must mainta staffing data for a n required by State la This REQUIREMENT by: Based on observation interview, the facility in the manner required facility in the manner r	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to post nursing hours in the manner required. This has the potential to affect all residents and visitors.	ROVIDER OR SUPPLIER NCE PLACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to post nursing hours in the manner required. This has the potential to affect all residents and visitors. Findings include: Posted nursing hours for public display on 12/5/16, at 11:30 a.m. the nursing hours posted were dated 12/5/16. On 12/7/16, at 9:45 a.m. the director of nursing (DON) explained that according to the facility's policy, they had until 10:00 a.m. to ensure the hours were posted for the day. They were "in the process" of posting the hours, and later the hours reflected staffing for 12/7/16. In an interview with the staffing coordinator on 12/7/16, at approximately 11:00 a.m. she stated the staff had been told effective that day (12/7/16) she had been informed there was a	ROVIDER OR SUPPLIER NCE PLACE SUMMARY STATEMENT OF DEFICIENCIES [EACH OERICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION] Continued From page 10 (3) Public access to posted nurse staffing data. The facility must. upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to post nursing hours in the manner required. This has the potential to affect all residents and visitors. Findings include: Posted nursing hours for public display on 12/5/16, at 11:30 a.m. the nursing hours posted were dated 12/5/16. On 12/7/16, at 9:45 a.m. the director of nursing (DON) explained that according to the facility's policy, they had until 10:00 a.m. to ensure the hours were posted for the day. They were "in the process" of posting the hours, and later the hours reflected staffing for 12/7/16. A. Hoe executive director and/or designee. The date reviewed/discussed at the monthl assurance meeting. At this time it committee will make the decision/recommendation regardin necessary follow up studies.	A BUILDING 245271 B WING STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407 SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to post nursing hours in the manner required. This has the potential to affect all residents and visitors. Findings include: Posted nursing hours for public display on 12/5/16, at 11:45 a.m. were dated 12/4/16. On 2/6/16, at 11:30 a.m. the nursing hours posted were dated 12/5/16. On 12/7/16, at 94-54 a.m. the director of nursing (DON) explained that according to the facility's policy, they had until 10:00 a.m. to ensure the hours were posted for the day. They were "in the process" of posting the hours, and later the hours reflected staffing for 12/7/16. The data collected will be presented to the QAPI committee will make the decision/recommendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245271	B. WING _			C 08/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	·	
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F 356	483.55(b)(1)(2)(5) F	the previous day's staffing.	F 35			1/17/17
SS=D	resource, in accordance, the following dineeds of each resident	or obtain from an outside ance with §483.70(g) of this ental services to meet the lent:				
	the resident- (i) In making appoint (ii) By arranging for dental services local (b)(5) Must assist rewish to participate to dental services as a under the State plant. This REQUIREMENT by: Based on observative review the facility facility facility facility facility facility.	esary or if requested, assist entments; and transportation to and from the tions; esidents who are eligible and apply for reimbursement of an incurred medical expense in. It is not met as evidenced ion, interview and record iled to ensure appropriate 3 residents (R123) whose		1. With respect to R123, a denta appointment was scheduled on 12 2. All resident records have been by health information to ensure the been offered dental care/services the past 12 months.	2/7/16. audited ey have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 412	p.m. she had missi dentist. She said th the problem "a whil hear back from the A dental assessme R123 had missing thowever, the reside desired to see a de R123's telephone prevealed the reside antibiotic for "tooth appointment with a possible." In additio for oral pain) was offected tooth. On 8/6/16, a A Gen record read, "Reside tooth infection." A Gindicated the reside scheduled dental a ill. On 11/6/16, an Ora "Allowed oral exam UDA [dental activity regarding teeth, lips pain." On 11/17/16, read, "A mini-nutritic completed on [R12 which indicates at read interview on 12/17.	nterview on 12/5/16, at 5:36 ng teeth and needed to see a e facility was made aware of e ago," and she was waiting to	F 412	3. All health information staff will I re-educated by 1/17/17 regarding guidelines and process for dental and other ancillary services. 4. The director of Nursing and/or designee will complete 2 resident audits each week for one month a 1 resident chart per week for two to assure dental services are offer obtained as requested. 5. The data collected will be prese QAPI be the director of nursing. Twill be reviewed/discussed and decision/recommendations mad reany necessary follow up studies.	chart nd then months ed and ented at The data	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	243211	B. Willa	STREET ADDRESS, CITY, STATE, ZIP CODE	12	/08/2016	
PROVIDE	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ULD BE	(X5) COMPLETION DATE	
F 412	had been canceled rescheduled. Later p.m. HIC-C said shith that day with Door Sconfirmed facility stappointments and a said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be said she did not know "hopefully she can lead to be sai	ill that day, the appointment and had not been that day at 12/07/16, at 1:07 to had set up an appointment of the set up and the needs of each resident. The facility must provide the set up and the needs of each resident. The facility must provide the needs of each resident. The facility must provide and the needs of each resident. The facility must provide and the needs of each resident.	F 4	.12		1/17/17	
	disposition of all co	rstem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245271	B. WING				08/ 2016
	PROVIDER OR SUPPLIER			3720	EET ADDRESS, CITY, STATE, ZIP CODE 23RD AVENUE SOUTH NEAPOLIS, MN 55407		
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F 431	that an account of a maintained and per (g) Labeling of Drug Drugs and biological labeled in accordar professional principal appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance with the facility must stolocked compartment controls, and permitave access to the	t drug records are in order and all controlled drugs is riodically reconciled. gs and Biologicals. als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when see and Biologicals. with State and Federal laws, are all drugs and biologicals in the under proper temperature it only authorized personnel to	F 4	31	DEFICIENCY)		
	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distriquantity stored is more readily detected. This REQUIREMED by: Based on observareview, the facility frequiring refrigeratitemperature range refrigerators, havin residents (R44, R2)	d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the ninimal and a missing dose can. NT is not met as evidenced tion, interview and document ailed to maintain medications on within acceptable in 2 of 5 medication g the potential to affect 11 89, R207, R290, R21, R123, R212, R141) whose		n v re ic n	1. With respect to the identified nedications and refrigerators, pharwas consulted to determine medicatequiring disposal and replacement dentified refrigerators were checken aintenance and adjusted to the permoderature.	ations t. The ed by roper	

245271 B. WING 12/08/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
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3720 23RD AVENUE SOUTH		
PROVIDENCE PLACE MINNEAPOLIS, MN 55407		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431 Continued From page 15 F 431		
temperatures, and to properly label and/or store medications with shortened expiration dates for 4 residents (R44, R106, R97, R123) whose medications were not labeled when opened and/or were not properly refrigerated when unopened. The facility's medication refrigerator log indicated temperatures were to be maintained between 36-46 degrees Fahrenheit (F). The manufacturer's package insert recommendations directed the user to store medications between 36-46 degrees to maintain medication shelveen 36-46 degrees to maintain medication between 36-46 degrees to maintain medication wiability and to discard medications bath had been frozen. The medication storage system was reviewed on the 2 north (2N) unit on 12/5/16, at 3/49 p.m. with registered nurse (RN)-E. RN-E verlified the thermometer registered 32 degrees F (i.e. freezing). RN-E explained, "The night nurse usually checks and records the temperature," and then asked to be excused as his shift had ended. At 3:55 p.m. trained medication aide (TMA)-C then verified medications that were stored in the refrigerator and labeled with current physician orders as follows: R44's gabapentin solution for seizure control and lansoprazole for gastroesophageal reflux both per tube feeding, as well as Levemir and Novolog insulin vials for diabetic control R289's unopened bottle of Acetylcyst sol 20% nebulizer for airway disease R207's Lantus insulin for diabetes control		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245271	B. WING			C 08/2016	
	PROVIDER OR SUPPLIER	- 13-11		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	12/	00/2010	
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F 431	In addition, stock m potential resident a vial of tuberculin pu and one vial of influ unlabeled vial of Tri The following list of the 3N refrigerator aby RN-H: R288's gabapentin suspension both per R199's Vancomycir R149's Novolin insurable R212's pneumovax injection vaccination booster on 12/5/16, 4:21 p. medication refrigerate, which was above stated, "The night in sure temperature is On 12/5/16, at 7:11 of the temperature	Lantus insulins Lantus insulins Julin per sliding scale per blood service stored for and/or staff that included one arified protein derivative (PPD) arenza virus vaccine, and an	F 4	31			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		2/00/2010
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F 431	consultant also veri refrigerator register. During an interview stated "I have work years. I check the rishift. The normal racould be wrong. I hon the log." At 1:05 p.m. RN-A temperature of the normal range shout there is a lack of aveducation." On 12/7/16, at 1:12 (LPN)-A reported, "medication room. I beginning of my ship between 30 and 46 until it comes between than two hours to a call maintenance at RN-H was then ask temperature range honestI do not known and the interview of the intervi	ees F. At 7:34 p.m. the nurse fied temperature in 2N		31		

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	-	COM	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 3720 23RD AVENUE SOUT MINNEAPOLIS, MN 554	н	<u> 12/</u>	00/2010
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F 431	12/8/16, at 1:54 p.n [maintenance] issue on the maintenance wice a day." The Drecord of any staff refrigerator temperaranges, nor had he the problem. He starefrigerator on the 2 observations as, "It checked on it." 2N refrigerator temperatures below months. December 12/1 and 12/2, and was recorded at 30 days in 11/16 tempelog. Out of range te 30 degrees on 11/2 11/30; 31 degrees on 11/2 11/30; 31 degrees on 11/1 11/7, 11/9, 11/10, and temperatures were were below accepted degrees) for 14 day missing on nine day nearly all below nor 3N logs revealed te for November: 11/1 through 10/5, 10/8, 10/30; September: 9/30/16.	ntenance (DM) stated on n. "If there are any es, I tell nursing staff to write e board, and I check the log M said he did not have a reporting issues with atures being out of acceptable received any calls related to sted he had replaced one 2N unit following the surveyor's was 32 degrees when I perature logs revealed as 36 degrees in the previous in No data was recorded on on 12/3, 12/4, and on 12/5 it degrees. November: Nine peratures were missing on the mperatures were recorded at 11/4, 11/11, 11/12, 11/24, and on 11/21, 32 degrees on 11/5, 14, and 34 degrees on 11/6,		31			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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F 431	document refrigera temperatures must 46 Fahrenheit." In addition, the faci medications on the 12/8/16, at 9:06 a.r. R44's unopened via medication cart. Ri indicated the vial wunopened, and a si Novolog was also ithe unopened vial si refrigerator, and did medication in the ci RN-E explained op days after opening. R106's opened and was in the cart. RN labeled when open remaining. The pharm RN-E was unsure in viable after opening somewhere at the frames for shortened. On 12/8/16, at 9:32 been made aware time frames after mestimes.	I staff to "Monitor and tor temperatures. Refrigerator to be maintained between 36 to lity failed to properly store 2N medication carts on m. al of Novolog was stored in the N-E verified the pharmacy label as delivered on 12/6/16, was econd nearly full vial of the cart for R44. RN-E stated should have been stored in the drot know who had put the art versus the refrigerator. ened vials were viable for 28 drond undated Symbicort inhaler ed and had 60 uses armacy label read 11/12/16. Now long the Symbicort was g, but said there was a sheet nurses' station indicated time				
	a.m. nurses had be upon opening and	/8/16, at approximately 10:00 een trained to date the vials were responsible for checking tions when they administered				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG	CON	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		700/2010
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F 431	RN-E had reviewed schedules, and fou unlabeled medicatic checked the carts. On 12/8/16, at 10:2 new insulin vials we were opened for us days after opening. expiration dates an opening. RN-G expiration dates an opening. RN-G expiration dates and Combivent Respiration dates and Combiven	then they cleaned the carts. If the medication cleaning and no concerns about ons the last time she had as a.m. RN-G stated unopened are to be refrigerated until they are, and then were viable for 28 RN-G stated she checked at they were to be dated upon plained some inhalers were and others for three months. In the inhalers on cart 2 were and including Flovent, Ventolin, shimat inhalers. In on 12/8/16, RN-A verified art 2) had been opened and as left, but had not been dated aler had been opened but was ened. RN-A verified there were maining.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	` '	E SURVEY PLETED
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	PROVIDER OR SUPPLIER			372	REET ADDRESS, CITY, STATE, ZIP CODE 10 23RD AVENUE SOUTH NNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 SS=E	determine if the two destroyed, and to v had been delivered TMAs had been tranot on a card and w provided on the from The facility's 8/15, Nexpiration Guideline indicated, "Symbioc Room Temp [temperand Date When Opfound undated when have been opened unopened vials of in refrigerator until opensed days after the fir 483.80(a)(1)(2)(4)(e) PREVENT SPREA (a) Infection preventation of the facility must estand control programa minimum, the following services of the facility of the facility must estand control programa minimum, the following services of the facility of the facility must estand control programa minimum, the following services of the facility of the facility must estand control programa minimum, the following services of the facility of the facility must estand control programa minimum, the following services of the facility o	o with the pharmacist to vials of insulin needed to be erify the date the Symbicort. The DON stated nurses and ined to date any medications were aware of the guidelines at of the MARs. Medication Storage And the strong the pharmacy out Inhaler is to be stored at erature] 3 Months after 1 Use the medications in opened will be presumed to as of the date of." In addition, insulin were to be stored in the ened then dated and expired st use. Exp(f) INFECTION CONTROL, D, LINENS Intion and control program. Intablish an infection prevention in (IPCP) that must include, at owing elements: Expenting, identifying, reporting, ontrolling infections and eases for all residents, staff, and other individuals under a contractual disponsible the standards (facility assessment and the standards (facil	F 4				1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245271	B. WING			12/0	08/ 2016	
	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 8720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		, = 0.10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	limited to: (i) A system of surv possible communic before they can spr facility; (ii) When and to wh communicable diserported; (iii) Standard and tr to be followed to profession of the followed to profession of the facility of the followed to profession of the facility of the followed to profession of the facility	eillance designed to identify able diseases or infections read to other persons in the some possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a out not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct into or their food, if direct the disease; and the procedures to be followed direct residents ontact.	F 4	141				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		COMI	SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	CODE		, -
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD IE APPROPE	BE	(X5) COMPLETION DATE
F 441	(e) Linens. Person process, and transpapered of infection. (f) Annual review. annual review of its program, as necess. This REQUIREMED by: Based on observareview the facility fahandwashing/infect (R91) whose wound addition, the facility sanitation technique medication administ (R37, R91, R234) wadministration was Findings include: R91 was asked if his brief changed on 12 and NA-B. R91 reproceeded to assis wiped R91, a dress buttocks. RN-D was and said she would dressing. At 9:10 a washed her hands supplies. RN-D dor cleansed R91's wo Without removing gapplying clean glovo ointment. Although were available on the proceeded to R91's wo work and said she would dressing. The clean glovo ointment. Although were available on the proceeding of the proceeding policy to R91's work applied to R91's work applied to R91's work and said she would dressing. At 9:10 a washed her hands supplies. RN-D dor cleansed R91's work applying clean glovo ointment. Although were available on the proceeding policy to R91's work applied to R91's	The facility will conduct an IPCP and update their sary. NT is not met as evidenced tion, interview and document ailed to follow proper tion control for 1 of 2 residents d care was observed. In failed to ensure proper hand e was performed during stration for 3 of 10 residents whose medication	F 4	1. With regards to the ide employees: Education has regarding hand washing. 2. Infection control reports and no trends were identification passes and tresprevent the transmission of and possible infection. 3. All nursing staff will rector proper technique regarder hand washing. Educat completed by 1/17/17. 4. The director of nursing designee will audit two state one month and then one stort two months to ensure proper washing, audits of licenses medication passes and trecompleted 2 per week for then 1 per week for two months. The data collected will the QAPI committee by the nursing. The data will be reviewed/discussed at the meeting. At this time the completes are commendation necessary follow up studies.	s been prosented by the committee on regarding process. The committee on regarding process and/or one montonths.	viewed by will be during to ens cation cedure e eek for reek nd for will be th and nted to of QAPI e will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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F 441	supplies and placed the room, and left thands. On 12/7/16, at 9:25 change my gloves"	age 24 d them in a dresser drawer in he room without washing her s a.m. RN-D stated, "I forgot to between cleansing the wound dressing. RN-D said, "I was a	F 4	41		
	nursing stated whe performed, nurses hands, donned glov and cleaned the wo to be removed, har gloves applied. Oin	ing at 10:11 a.m the director of n dressing changes were should have first washed their wes, removed the old dressing bund. Gloves would then need hads re-washed, and clean atment would then be used, a ed, followed by glove removal				
	staff as follows: "W requiring the use of	Hand Washing policy directed then conducting a procedure f gloves, proper hand washing before donning gloves and res."				
	12/5/16, at 5:28 p.n (TMA)-A reported s medications on the to go to the third flomedication to resid south (3S) unit, she through the medication cart (ide TMA-A took a single proceeded to the cattending an activity	administration observation on n. trained medication aide the was finished passing 2 south (2S) unit, and needed for to continue passing ents. Upon arriving on the 3 eximmediately began paging ation administration record ocated on top of the entified as the team one cart). The medication for R234 and formon area the resident was y, and gave R234 the pill.				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DENTIFICATION NUMBER: (X3) MULTIPLE CONSTRUCTION (X3) A. BUILDING (X3)		(X3) DATE SURVE	COMPLETED				
		245271	B. WING			6		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	COMPLETED C 12/08/20 TY, STATE, ZIP CODE SOUTH N 55407 R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE COMPLETED COM			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉ	TION		
F 441	medication from the to the resident's root TMA-A then returns states she had finis When asked about administering medi between residents washed her hands further explained slin the medication carts, T product on either medication carts, T product on the registered nurse, (F always sanitize the administration and When staff comes important because touched on their wainfection control." Suse Purell (instant lalcohol) along with policy stated. On 12/8/16, at 1:27 nurse, (LPN)-B verinot located on the texplained the facilitias needed and explained the facilitias needed needed needed needed needed needed needed needed needed	MAR. She then took a single cart for R37. She then went om, but she was not there. The dot to the medication cart and shed her medication pass. Sanitizing her hands prior to cation to a resident as well as TMA-A reported she had "on the other unit" (2S). She had used the hand sanitizer art to disinfect her hands. We the hand sanitizer on the MA-A was unable to locate the redication cart. TMA-A stated sed hand sanitizer when she dication cart, she had failed to the rearriving on a new unit and the medication to residents. Ton 12/8/16, at 1:11 p.m. and the unit it is especially we do not know what they are to the explained the policy was to the explained the policy was to the explained the policy was to the analysis and the facility's and a licensed practical fied Purell hand sanitizer was eam one cart on 2S. She y stocked the hand sanitizer ected it to be available in all We brought two new ones this morning. Our policy is that three times and then we must the times and the times and the times times and the times times and the times times the times and the times times the times and the times times the times tim						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	CON	TE SURVEY MPLETED
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_	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		, 00, 20 : 0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	RN-A on 12/5/16, a medication to the re RN-A then returned she proceeded to sunknown resident visanitizing her hands with another two reintervened and ask during a medication would wash her hands asked if she had wast he medication passineeded to." The meany available hand go to the sink if she on 12/8/16, at 11:2 explained the expetitheir hands betwee administration, and hands if they were administer the medicand then go on to the sink if she and then go on to the same and then go on to the same and then go on to the same and the medication and the medication and then go on to the same and the medication and the same and the medication and the same and technique sanitize their hands	ras set up for administration by the 6:20 p.m. who then gave the esident in the dining room. It to the medication cart where et up medication for an without first washing or s. RN-A continued the process sidents. The surveyor ed RN-A about hand washing in pass. RN-A reported she hads "If they were dirty." When ashed her hands at all during is she replied, "NoI have not edication cart did not contain sanitizer. RN-A said she could a needed to clean her hands. O a.m. the RN consultant contain was for staff to sanitize in resident's medication was their wisibly soiled. "They should ications, sanitize their hands,	F 44	.1		

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Printed: 12/19/2016 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245271

B. WING.

12/13/2016

NAME OF PROVIDER OR SUPPLIER

PROVIDENCE PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE

3720 23RD AVENUE SOUTH

	Willy	INEAPOLIS, M		(VE)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)	DRY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS	K 000			
	FIRE SAFETY	»:	8		
12	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 13, 2016. At the time of this survey, Providence Place was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.			^	
	Providence Place is a 3-story building with a ful basement. The building was constructed at 2 different times. The original building was constructed in 1984 and was determined to be Type II(222) construction. In 1995, an addition was constructed to the North side of the buildin that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors at spaces open to the corridor, that is monitored fautomatic fire department notification. The facil has a licensed capacity of 181 beds and had a census of 170 at the time of the survey.	of g as n nd or			
	The requirement at 42 CFR, Subpart 483.70(a) MET.	is			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 27, 2016

Mr. Tyler Donahue, Administrator Providence Place 3720 23rd Avenue South Minneapolis, Minnesota 55407

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5271028, H5271186, H5271188

Dear Mr. Donahue:

The above facility was surveyed on December 5, 2016 through December 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5271186 and H5271188. that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Providence Place December 27, 2016 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00096	B. WING		12/0	, 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the matter of t	nether a violation has been				
	When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ns several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 01/11/17

TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/5/16 through 12/9/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. At the time of the State licensing survey, investigations were conducted into complaints H5271186 and H5271188. The complaints were not substantiated. 2 570 MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility	-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407				A. BUILDING:			,
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CALL DEPONDENCE PLACE MINNEAPOLIS, MN 55407	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PREFIX TAG PREFIX PREFIX PREFIX PRECIDENCY MIST BE PRECEDED BY FULL PREFIX TAG PREFIX TAG PRECIDENCY PREFIX TAG PREFIX TA	PROVIDI	ENCE PLACE					
Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/5/16 through 12/9/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. At the time of the State licensing survey, investigations were conducted into complaints H5271186 and H5271188. The complaints were not substantiated. 2 570 MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.		Department of Hea you electronically, is necessary for State necessary for State enter the word "correct. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff the following correction that you and identify the date. At the time of the S investigations were H5271186 and H52 not substantiated. MN Rule 4658.0405 Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 12/9/16, surveyors of this visited the above provider and ction orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed. tate licensing survey, conducted into complaints conducted into complaints were. Subp. 4 Comprehensive plan of wed and revised by an methat includes the attending red nurse with responsibility dother appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least a seven days of the revision of resident assessment required				1/17/17

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 2 of 23 JXE811

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7.110 1 27.114	0. 0020014	BENTH TO THE TOTAL BETTE	A. BUILDING:			
		00096	B. WING		12/0) 8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVIDI	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa		2 570			
	by: Based on observati review, the facility fa services to minimiz development of pre	ent is not met as evidenced on, interview and document ailed to provide care and e the risk for further ssure ulcers for 1 of 2 viewed with pressure ulcers.		Acknowledged		
	Findings include:					
	2/12/14), indicated for pressure ulcer of immobility, diabetes Interventions include	e plan for R149 (revised on the resident had the potential levelopment related to s, incontinence, and sheering. ed turning and repositioning at rs, or more frequently as ed.				
	from 12:10 p.m. unrepositioning. At 12 the dining room eat nurse (RN)-I assisted performed a dressing feet. At 1:20 an existed the resident but was the room, and no rewas offered or performance was in R149's room his wheelchair with 1:53 when the resident was not assistant (NA-C) as needed anything. Wincontinence brief or resident denied being "Not now." Repositing RN-I stated there we from 2:30 to 3:00.	d continuously on 12/7/16, til 2:48 p.m. without :10 he was in a wheelchair in ing lunch. At 1:04 registered ed R149 to his room and ng change as ordered to both ercise activity was offered to see declined. At 1:22 RN-I left expositioning in the wheelchair formed during the time RN-I in R149 remained seated in his eyes closed from 1:28 until lent's vital signs were taken; it repositioned. Nursing sked R149 at 2:03 if he When asked if he needed his hanged or to use the toilet the ing incontinent and replied, oning was not offered. At 2:38 ere only two NAs on the floor at 2:44 NA-A stated R149 was group" but she was "covering"				

Minnesota Department of Health

STATE FORM JXE811 If continuation sheet 3 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00096	B. WING		12/0)8/ 2016
-	PROVIDER OR SUPPLIER	3720 23RI	DRESS, CITY, S D AVENUE S OLIS, MN 59			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	for NA-B. NA-A state every two hours, but when R149 had las "I would not know," report when she arremained in his who buring a staff intervative registered nursed developed a pressubilateral (both sides the pressure areas lower extremities as shoes to become time were unstageable (Wound Summary State cause of both the ulcers as pressure R149's most recent assessment dated was at risk for skin of diabetes, lymphe and bladder, and infurther indicated R1 breakdown at that the R149's Comprehent Evaluation dated 9/skin factors for the skin often moist, very potential problem for R149's quarterly Mindicated the reside ulcers on his feet. Find the state of the skin often moist, we potential problem for R149's quarterly Mindicated the reside ulcers on his feet.	ed staff was to offload R149 at she was unable to state t been repositioned explaining, and stated she did not get a rived on the unit. At 2:48 R149 relchair without repositioning. Fiew on 12/5/16, at 5:10 p.m. Fiew	2 570			

Minnesota Department of Health

STATE FORM JXE811 If continuation sheet 4 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00096	B. WING			C 08/2016
	PROVIDER OR SUPPLIER	3720 23RI	DRESS, CITY, S D AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 570	The Active [physicial directed staff to offloor standing) from the if the resident permitted for R149 were required for R149 were required a staff intervent RN-D stated nursing report off to oncoming shift. She further stapolicy or standardize process. She further Point of Care, but redocumented versus repositioned. On 12/8/16, at 10:5 stated she expected residents as directed the individual needs. The facility's 9/10, For Prevention Program directed staff to mo pressure ulcer prevention the incidency of the incidency of the individual needs. SUGGESTED MET DON or designee considents who requires with requirements with requirements.	an] Orders as of 11/25/16, oad (relieve pressure by lifting he wheelchair every two hours itted (start date of 7/29/13). ent Administration Record ad from wheelchair every hour d. Weekly wound flow sheets ested but not obtained. Tiew on 12/7/16, at 2:58 p.m. g assistants (NAs) were to ing NAs at the end of their ated there was no written ed report sheet used for this er stated the NAs reported in effected the time it was at the time it was at the time the resident was at an at the director of nursing destaff to provide care to be done the resident. Providence Place Pressure in Policy and Procedure nitor the effectiveness of the ention program to reduce the rogression of pressure ulcers, ce and prevalence of pressure collity, and monitor adherences sedures for consistency in formance with the current	2 570			

Minnesota Department of Health

STATE FORM JXE811 If continuation sheet 5 of 23

(X3) DATE SURVEY

Minnesota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00096	B. WING		12/0) 8/2016
	PROVIDER OR SUPPLIER	3720 23RI	DRESS, CITY, S D AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	approaches. Nursin then audits conduct results of the audits quality committee for	g staff could be educated and ed to ensure compliance. The could be brought to the	2 570			
2 905	Subp. 4. Positioning positioned in good to of residents unable must be changed at including periods of been put to bed for has documented the hours during this ting the physician has of the physicia	g. Residents must be body alignment. The position to change their own position to least every two hours, time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or redered a different interval. The positioning every two network the night, unless the physician at repositioning every two network the night, unless the physician at repositioning every two network the period is unnecessary or redered a different interval. The positioning every two network the period is unnecessary or redered a different interval.	2 905	Acknowledged		1/17/17
	Findings include: R149 was observed from 12:10 p.m. unt repositioning. At 12 the dining room eat nurse (RN)-I assiste performed a dressir feet. At 1:20 an exe	I continuously on 12/7/16,				

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE COMP	SURVEY LETED		
			A. BOILDING.			
		00096	B. WING			8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	the room, and no re was offered or perfewas in R149's room his wheelchair with 1:53 when the resident was not assistant (NA-C) as needed anything. Wincontinence brief or resident denied bei "Not now." Repositi RN-I stated there we from 2:30 to 3:00. Anot in her "regular of for NA-B. NA-A state every two hours, but when R149 had las "I would not know," report when she arremained in his who During a staff intervathe registered nursed developed a pressubilateral (both sides the pressure areas lower extremities as shoes to become the were unstageable (Wound Summary State Cause of both the ulcers as pressure The current care ple 2/12/14), indicated for pressure ulcer of immobility, diabeted Interventions included the state of the cause of t	epositioning in the wheelchair ormed during the time RN-In. R149 remained seated in his eyes closed from 1:28 until dent's vital signs were taken; of the repositioned. Nursing sked R149 at 2:03 if he When asked if he needed his changed or to use the toilet the right incontinent and replied, oning was not offered. At 2:38 rere only two NAs on the floor at 2:44 NA-A stated R149 was group" but she was "covering" red staff was to offload R149 at she was unable to state to been repositioned explaining, and stated she did not get a rived on the unit. At 2:48 R149 relechair without repositioning. Friew on 12/5/16, at 5:10 p.m. or (RN-D) stated R149 had are ulcer on each of his great toes. She explained were due to edema in his red feet which caused his get resulting in pressure, and could not be visualized). A sheet dated 11/30/16, identified he left and the right great toe related and facility acquired. The R149 (revised on the resident had the potential levelopment related to so, incontinence, and sheering, ed turning and repositioning at rrs, or more frequently as	2 905			

Minnesota Department of Health

STATE FORM JXE811 If continuation sheet 7 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
,	0. 0020		A. BUILDING:			
		00096	B. WING		12/0	; 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		D AVENUE S POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 7	2 905			
	assessment dated was at risk for skin of diabetes, lymphe and bladder, and in further indicated R1 breakdown at that t					
	Evaluation dated 9/ skin factors for the skin often moist, ve	sive Skin and Positioning 2/16, identified contributing resident including chair fast, ry limited mobility, and or friction and sheer.				
	12/1/16, required ex staff for bed mobilit indicated the reside ulcers on his feet. F	nimum Data Set (MDS) dated stensive assistance of two y and transfers. The MDS ent had two existing pressure he had pressure relieving and bed, but did not have a oning program.				
	directed staff to offlor standing) from the if the resident perm. The current Treatm directs staff to offlor if resident permitted.	an] Orders as of 11/25/16, oad (relieve pressure by lifting the wheelchair every two hours itted (start date of 7/29/13). ent Administration Record ad from wheelchair every hour d. Weekly wound flow sheets ested but not obtained.				
	RN-D stated nursin report off to oncome shift. She further state policy or standardiz process. She further Point of Care, but re	riew on 12/7/16, at 2:58 p.m. g assistants (NAs) were to ing NAs at the end of their ated there was no written ed report sheet used for this er stated the NAs reported in eflected the time it was a the time the resident was				

Minnesota Department of Health

STATE FORM JXE811 If continuation sheet 8 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00096	B. WING		12/0)8/ 2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		D AVENUE S POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 8	2 905			
	repositioned.					
	stated she expecter residents as directed the individual needs	4 a.m. the director of nursing d staff to provide care to ed in their care plans to meet s of the resident. Providence Place Pressure				
	Prevention Program directed staff to mo pressure ulcer prev development and p monitor the incidence ulcers within the facto policies and process.	n Policy and Procedure nitor the effectiveness of the ention program to reduce the rogression of pressure ulcers, ce and prevalence of pressure cility, and monitor adherences redures for consistency in formance with the current				
	DON or designee c residents who requi repositioning. Appro and then audits cor	THOD OF CORRECTION: The ould review the cares for all ire staffs' assistance with opriate staff could be educated aducted to ensure compliance. udits could be brought to the or review.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21335	MN Rule 4658.0725 Routine & Emerger	5 Subp. 3 A&B Providing ncy Oral Health Ser	21335			1/17/17
	Subp. 3. Emergend	cy dental services.				
	from an outside res services to meet the Emergency dental s	ome must provide, or obtain ource, emergency dental e needs of each resident. services include services a episode of acute pain in				

Minnesota Department of Health

STATE FORM 5899 JXE811 If continuation sheet 9 of 23

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		2000			10/0	
		00096			12/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PROVIDE	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21335	Continued From pa	ge 9	21335			
	damaged teeth; or a cavity, appropriately requires immediate B. When emerginursing home mushours, describe the document and impliorders.	gency dental problems arise, a t contact a dentist within 24 dental problem, and ement the dentist's plans and				
	by: Based on observati review the facility fa	on, interview and record illed to ensure appropriate 3 residents (R123) whose eviewed.		Acknowledged		
	Findings include:					
	p.m. she had missin dentist. She said the	nterview on 12/5/16, at 5:36 and teeth and needed to see a e facility was made aware of e ago," and she was waiting to m.				
	R123 had missing the however, the resident	nt dated 11/11/16, identified eeth. There was no evidence, ent had been asked if she ntist regarding the problem.				
	revealed the reside antibiotic for "tooth appointment with a possible." In additio	hysician's order dated 8/3/16, nt was started on an oral abscessset up an dentist for ASAP [as soon as n, Oragel (topical medication rdered four times daily to the				

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On 8/6/16, a A General Note in R123's medical

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00096	B. WING		12/0) 8/2016
	PROVIDER OR SUPPLIER ENCE PLACE	3720 23RI	DRESS, CITY, S DAVENUE S OLIS, MN 59			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21335	record read, "Reside tooth infection." A Condicated the resides scheduled dental aprill. On 11/6/16, an Ora "Allowed oral exam UDA [dental activity regarding teeth, lips pain." On 11/17/16, read, "A mini-nutritic completed on [R12: which indicates at rowspan to the completed on the confirmed facility stappointments and a said she did not know the completed of the complete of	ent is on ABX [antibiotic] for deneral Note dated 8/18/16, ent refused to go to a appointment as she was feeling. I Dental Note indicated R123 to be completed: Yes. See report] for further details and mouth at a Mini Nutritional Note onal assessment was allnutritional risk score is 8.0 isk of malnutrition" Ition clerk (HIC)-A explained in 7/16, at 9:35 a.m. R123 had see the dentist on 8/8/16. Itill that day, the appointment and had not been that day at 12/07/16, at 1:07 to had set up an appointment and had not been that day at 12/07/16, at 1:07 to had set up an appointment and had not been that day at 12/07/16, at 1:07 to had set up an appointment and had not been aff made all of R123. She aff made all of R123's arranged transportation and the seen next week." RN)-A confirmed R123 was gan interview on 12/7/16, at ted dental assessments were	21335			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00096	B. WING			C 08/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
PROVIDI	ENCE PLACE		D AVENUE S OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21335	Continued From pa	ge 11	21335				
	for review.						
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			1/17/17	
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.						
	by: Based on observati review the facility fa handwashing/infect (R91) whose wound addition, the facility sanitation technique			Acknowledged			
	Findings include:						
	brief changed on 12 and NA-B. R91 rep proceeded to assist wiped R91, a dress buttocks. RN-D was and said she would dressing. At 9:10 a. washed her hands supplies. RN-D don	e wanted his incontinence 2/7/16, at 9:07 a.m. by NA-E lied affirmatively, and the NAs t him with the cares. As the NA ing bandage came off his then apprised of the problem be in to change R91's m. RN-D entered room in the bathroom and gathered and and rinsed it with saline					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00096	=		12/0) 8/2016
	PROVIDER OR SUPPLIER	3720 23R	DRESS, CITY, S D AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETE DATE		
21375	Without removing gapplying clean glovo ointment. Although were available on the by RN-D. The clear applied to R91's wothrew the gloves in supplies and placed the room, and left thands. On 12/7/16, at 9:25 change my gloves" and applying new dlittle nervous." The following morn nursing stated when performed, nurses hands, donned glovand cleaned the woth to be removed, han gloves applied. Oin new dressing applied and hand washing. The facility's 11/14, staff as follows: "W requiring the use of shall be completed after removing glove. During medication and 12/5/16, at 5:28 p.m. (TMA)-A reported semedications on the to go to the third flomedication to residus outh (3S) unit, sheets	ploves, cleaning hands and es, RN-D proceeded to apply a second pair of clean gloves he table, they were not utilized in bandage was dated and bund. RN-D then removed and the trash can, gathered the dithem in a dresser drawer in the room without washing her a.m. RN-D stated, "I forgot to between cleansing the wound ressing. RN-D said, "I was a sing at 10:11 a.m the director of in dressing changes were should have first washed their res, removed the old dressing bund. Gloves would then need do re-washed, and clean them the would then be used, a red, followed by glove removal. Hand Washing policy directed then conducting a procedure gloves, proper hand washing before donning gloves and	21375			

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	na Department of Tie					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(-,		(X3) DATE	SURVEY LETED
AND FLAN	OF CORNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	LETED
					C)
		00096	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3720 23RI	D AVENUE S	SOUTH		
PROVID	ENCE PLACE		OLIS, MN 5			
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				BEI IGIEINGT)		
21375	Continued From pa	ge 13	21375			
	(MAR) which was lo	ocated on top of the				
		entified as the team one cart).				
		e medication for R234 and				
		ommon area the resident was				
		, and gave R234 the pill.				
		the medication cart and again				
		MAR. She then took a single				
		e cart for R37. She then went				
	to the resident's room, but she was not there. TMA-A then returned to the medication cart and					
	states she had finished her medication pass.					
		sanitizing her hands prior to				
		cation to a resident as well as				
		TMA-A reported she had				
		on the other unit" (2S). She				
		ne had used the hand sanitizer				
		art to disinfect her hands.				
		w the hand sanitizer on the MA-A was unable to locate the				
		edication cart. TMA-A stated				
		sed hand sanitizer when she				
		ication cart, she had failed to				
	clean her hands aft	er arriving on a new unit and				
	prior to administering	ng medication to residents.				
		on 12/8/16, at 1:11 p.m.				
		RN)-C stated, "Staff should				
		r hands prior medication in between each resident.				
		on the unit it is especially				
		we do not know what they				
		y. It is a safety issue for				
		he explained the policy was to				
		nand sanitizer containing ethyl				
		handwashing as the facility's				
	policy stated.					
	0-10/0/101 07	n na la lineana al municipal				
		p.m. a licensed practical fied Purell hand sanitizer was				
		eam one cart on 2S. She				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00096	B. WING		12/0) 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	explained the facilit as needed and exp medication carts. "V [Purell dispensers] we can use it up to wash our hands wit R91's medication to the read to sunknown resident we sanitizing her hands with another two resintervened and asked during a medication would wash her har asked if she had wasthe medication pass needed to." The meany available hand go to the sink if she On 12/8/16, at 11:20 explained the expectadministration, and hands if they were administer the medication and then go on to the staff to have available during meemployees to wash However, the policy time and technique	y stocked the hand sanitizer ected it to be available in all We brought two new ones this morning. Our policy is that three times and then we must h soap and water." Tas set up for administration by the 6:20 p.m. who then gave the esident in the dining room. To the medication cart where et up medication for an evithout first washing or some and some and washing in pass. RN-A continued the process esidents. The surveyor ed RN-A about hand washing in pass. RN-A reported she ands "If they were dirty." When ashed her hands at all during is she replied, "NoI have not edication cart did not contain sanitizer. RN-A said she could be needed to clean her hands. O a.m. the RN consultant contain was for staff to sanitize in resident's medication was their visibly soiled. "They should ications, sanitize their hands,	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) I			SURVEY LETED	
		00096	B. WING		12/0) 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	medication adminis SUGGESTED MET DON and infection or review infection cor are educated. Retu auditing could be co brought to the quali TIME PERIOD FOF (14) days. MN Rule 4658.1340 and Preparation Are Subpart 1. Storage must store all drugs under proper temper	tration or between residents. CHOD OF CORRECTION: The control prevention nurse could strol policies and ensure staff rn demonstration or other onducted and the results of the ty committee for review. CORRECTION: Fourteen	21375	DEI IOIENO I)		1/17/17
	access to the keys. This MN Requirements by: Based on observation review, the facility for requiring refrigeration temperature ranges refrigerators, having residents (R44, R28 R288, R199, R149, medications were stemperatures, and the medications with sharesidents (R44, R10 medications were not residents).	ent is not met as evidenced on, interview and document ailed to maintain medications on within acceptable in 2 of 5 medication g the potential to affect 11 39, R207, R290, R21, R123, R212, R141) whose		acknowledged		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
					С	
		00096	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PROVIDI	PROVIDENCE PLACE 3720 23F MINNEAI					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
21610	Continued From pa	ge 16	21610			
	temperatures were 36-46 degrees Fah manufacturer's pac directed the user to 36-46 degrees to mand to discard med The medication sto the 2 north (2N) univegistered nurse (R	kage insert recommendations store medications between naintain medication viability lications that had been frozen. rage system was reviewed on it on 12/5/16, at 3:49 p.m. with IN)-E. RN-E verified the				
	registered nurse (RN)-E. RN-E verified the thermometer registered 32 degrees F (i.e. freezing). RN-E explained, "The night nurse usually checks and records the temperature," and then asked to be excused as his shift had ended. At 3:55 p.m. trained medication aide (TMA)-C then verified medications that were stored in the refrigerator and labeled with current physician orders as follows:					
	lansoprazole for ga	olution for seizure control and stroesophageal reflux both per ell as Levemir and Novolog petic control				
	R289's unopened be nebulizer for airway	oottle of Acetylcyst sol 20% disease				
	R207's Lantus insu	lin for diabetes control				
	R290's Levemir and	d Novolog insulins				
	R21's Novolog and	Lantus insulins				
	R123's Novolog ins sugar testing result	ulin per sliding scale per blood s				
		nedications were stored for nd/or staff that included one				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		С	
		00096	B. WING			8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROVID	PROVIDENCE PLACE 3720 23R MINNEAF					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 17	21610			
	vial of tuberculin purified protein derivative (PPD) and one vial of influenza virus vaccine, and an unlabeled vial of Trulicity insulin.					
	The following list of medications were observed in the 3N refrigerator and the contents were verified by RN-H:					
	R288's gabapentin suspension both pe	solution and amoxicillin or gastrostomy tube				
	R199's Vancomycir	n intravenous antibiotic				
	R149's Novolin insu	ulin				
	R212's Pneumovax	23 single injection				
	R141's single inject Pneumovax injectic vaccination booster	on as well as Boostrix				
	medication refrigera	m. RN-H verified the 3N ator temperature registered 48 the acceptable range. RN-H nurse is responsible for making a correct."				
	of the temperature verified the temperature freezing at 32 degree	p.m. during a second check of the 2N refrigerator RN-A ature continued to register at sees F. At 7:34 p.m. the nurse fied temperature in 2N ed 32 degrees F.				
	stated "I have work years. I check the r shift. The normal ra	on 12/7/16 at 1:00 p.m. RN-B ed here for five and a half efrigerator temperature once a ange is between 36-40 FI ave to check the correct range				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00000	B. WING		10/0	
		00096	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PROVID	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 18	21610			
	At 1:05 p.m. RN-At temperature of the normal range shoul	hen stated "I check the refrigerator once a day. The d be between 36-46. I believe varenessWe need to do staff				
	(LPN)-A reported, "I medication room. I beginning of my shi between 30 and 46 until it comes betwee than two hours to accall maintenance ar RN-H was then ask temperature range honestI do not knorange, but I will get	p.m. licensed practical nurse I have full access to the check the refrigerator at the ft. It is supposed to be. I will adjust the temperature een the range. If it takes more djust to the correct range, I will not the infection control nurse." ed the correct refrigerator and replied, "I have to be ow the exact temperature back to you with that."				
	12:58 p.m. "I know staff to monitor eve refrigerator is within range temperatures notify the superviso supposed to audit a reported she was untemperatures had be	sing stated on 12/8/16, at it is a problem. I expect the ry day and ensure the range on all units. If out of a are noticed, they should r. The clinical directors are at least weekly." The DON naware the refrigerator seen out of range. The DON ator was replaced since the ions.				
	12/8/16, at 1:54 p.m [maintenance] issue on the maintenance twice a day." The D record of any staff r refrigerator temperaranges, nor had he	ntenance (DM) stated on n. "If there are any es, I tell nursing staff to write e board, and I check the log M said he did not have a eporting issues with atures being out of acceptable received any calls related to attend he had replaced one				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					C	;
		00096	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PROVIDI	ENCE PLACE		O AVENUE S OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE APPROPRIES OF	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 19	21610			
	refrigerator on the 2N unit following the surveyor's observations as, "It was 32 degrees when I checked on it."					
	temperatures below months. December 12/1 and 12/2, and was recorded at 30 days in 11/16 tempelog. Out of range te 30 degrees on 11/2 11/30; 31 degrees of 11/7, 11/10 and 11/1 11/7, 11/9, 11/10, at temperatures were were below acceptadegrees) for 14 day missing on nine day	perature logs revealed v 36 degrees in the previous: No data was recorded on on 12/3, 12/4, and on 12/5 it degrees. November: Nine eratures were missing on the mperatures were recorded at , 11/4, 11/11, 11/12, 11/24, and on 11/21, 32 degrees on 11/5, 14, and 34 degrees on 11/6, and 11/18. October: not recorded 10 days and able ranges (between 30-34 vs. September: Data was ys and temperatures were mal range at freezing.				
	for November: 11/1 through 10/5, 10/8,	mperatures were not recorded 6 and 11/17; October: 10/1 10/16, 10/17, 10/22 though 9/10, 9/11, 9/18-25, 9/29, and				
	Procedure directed document refrigera	Practice Guideline and staff to "Monitor and tor temperatures. Refrigerator be maintained between 36 to				
		ity failed to properly store 2N medication carts on า.				
		al of Novolog was stored in the I-E verified the pharmacy label				

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indicated the vial was delivered on 12/6/16, was

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00096	B. WING		12/0) 8/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
PROVIDENCE PLACE		O AVENUE S OLIS, MN 5			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
Novolog was also in the unopened vial sh refrigerator, and did medication in the car RN-E explained open days after opening. R106's opened and twas in the cart. RN-E labeled when opened remaining. The pharman RN-E was unsure however with the number of the pening, somewhere at the number of the frames for shortened. On 12/8/16, at 9:32 a been made aware of time frames after mean RN-A stated insuling with the pening and we for expired medication and when the pening and we for expired medication and when the pening and we for expired medication and when the pening and we for expired medication and when the pening and we for expired medication and when the pening and the pen	cond nearly full vial of the cart for R44. RN-E stated hould have been stored in the not know who had put the rt versus the refrigerator. The refrigerator in the refrigerator in the refrigerator. The refrigerator in the refrig	21610			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
					С		
		00096	B. WING		12/0	8/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
PROVIDENCE PLACE		D AVENUE S OLIS, MN 5					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21610	Continued From pa	ge 21	21610				
		inhalers on cart 2 were d, including Flovent, Ventolin, shimat inhalers.					
	R97's At 10:45 a.m. on 12/8/16, RN-A verified Ventolin inhaler (cart 2) had been opened and had 156 of 200 uses left, but had not been dated when opened.						
	R123's Flovent inhaler had been opened but was not dated when opened. RN-A verified there were 188 of 200 uses remaining.						
	In addition, a Symbicort inhaler with an illegible label was stored in the cart, and RN-A said she was "going to toss it."						
	On 12/8/16, at 9:44 a.m. the DON explained that the Guideline Sheet for medication viability time frame references for the nurses had been missed on the 12/16 medication administration records (MARs). The DON stated when new insulin vials were delivered from the pharmacy, they should have been placed in the refrigerator and then removed for administration, then vials dated and then stored in the medication carts. The DON planned to follow up with the pharmacist to determine if the two vials of insulin needed to be destroyed, and to verify the date the Symbicort had been delivered. The DON stated nurses and TMAs had been trained to date any medications not on a card and were aware of the guidelines provided on the front of the MARs.						
	Expiration Guideline indicated, "Symbico Room Temp [tempe and Date When Op	Medication Storage And es from the pharmacy ort Inhaler is to be stored at erature] 3 Months after 1 Use enSpecified medications n opened will be presumed to					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00006			C 12/08/2016	
NAME OF I	PROVIDER OR SUPPLIER	00096		STATE, ZIP CODE	12/0	8/2016
			D AVENUE S			
PROVIDI	ENCE PLACE	MINNEAP	OLIS, MN 5	5407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 22	21610			
	unopened vials of ir	as of the date of." In addition, asulin were to be stored in the ened then dated and expired st use.				
	SUGGESTED MET DON and other app such as the pharma storage practices to maintained at all time ducated as to the refrigerators could be able to maintain metemperature ranges demonstrations coulappropriate staff un ranges and how to Audits could be con appropriately check thermometers and it quality committee for	HOD OF CORRECTION: The propriate staff or consultants acist could review the facility's pensure medication viability is pess. Appropriate staff could be importance and system. The pe checked to ensure they are edications within appropriate at all times. Return all be required to ensure derstand the temperature read and record temperatures. Inducted to ensure staff are sing and reading the the results brought to the				

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